Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Robert L. Linnemann September Medical 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson Social Security Number If Under 1 Year If Linder 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 📈 M 2 🗆 F 216-58-0211 June 6. 1950 60 Maryland Director Usual Residence of Decedent 10b. County na State 10c. City, Town or Location Baltimore 10d. Inside City Limits Funeral Director Maryland 28a-f 1 X Yes 2 No 10f. Zip Code 21206 10g. Citizen of What Country? ō 10e. Street and Number 5418 Remmell Avenue items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, ٥, 1 X Never Married 2 Married Completed by Yes 2 X No Yes, Give White 1 ☐ Yes 2 X No Specify: Specify: 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) aaon Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stuart Linnemann Jeanette Simpson 19a. Informant's Name/Relationship (Type, Print)

Jeanette Linnemann/ Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5418 Remmell Avenue Baltimore Maryland 21206 permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 9/9/10 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck. Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **₽**h sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acute renal tailure Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of Seps.3 Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 1 Yes 2 9 Unknown Pregnant at time of death a Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mostral obesity 2 No 3 □ Probably 4 □ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an Chrome Venous insuff. page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 No ဂ္ 1 Natient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Brue Sabath MD D0070874 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PPE203 Towson Charles Street.

DHMH 17 Rev 7/2009

State Registrar

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 6, 2010 Evelyn Stehle Lakeman 8:59 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Numbe 8. Date of Birth Month, Day, \ February 9 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 □ M 2 🛛 F Months Hours Min. **Director** 217-16-7905 89 Usual Residence of Decedent 28a-f show 10a, State 10b. County within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4113 Spruell Drive 20895 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William F. Stehle Catherine Eiring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. James H. Lakeman/Husband 4113 Spruell Drive, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gate of Heaven Cemetery 1 X Burial 2 Cremation 3 Removal from State September 10 4 Donation 5 Other (Specify) 2010 Silver Spring, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, In 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ Acute and Chronic Respiratory Failure disease or condition resulting in death) ) Medical Due to (or as a consequence of): **Examiner** Malignant Pleural Effusion Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Breast Cancer Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical P.O. Box 6876( IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown should be detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Acute Pneumonia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Obstructive Pulmonary Disease Hospital or Attending Physician: The law has page 2 s performed? Yes 2X No cate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical this certif Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 X No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5  $\square$  Pending work' 1 🗆 Yes 2 🗆 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State

Registrar

30. Name and address of per-

ompleted cause of death (Item 23a) (Type, Print)

D52503

September 7, 2010

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of Maryland / Department of Health and I	Mental Hygie	ne oolo ooloo
		1 - State Registrar	Certificate of Death	Reg.	
Physicia Medi		1. Decedent's Name (First, Middle, Last) Dorothy	Montgomery	2. Date of Death	Day 2010 8:30 M
Examir		4a. Facility Name (if not institution, gives	treet and number) 4b. City, Town, or Location of Death A A A A A A A A A A A A A A A A A A A		4c. County of Death
Funeral Director	Г	5. Social Security Number 6 Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yes	9. Birthplace (State or Foreign 1928 North Carolina
3	١	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Location	11101.15,1	10d. Inside City Limits
Marylar 28a-f sl otified	irecto	Md. N/A	1 Baltimore		1 XÝes 2 □ No
Aaryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral Director	2806 Brial	ton St. 2/2/6	10g	Citizen of What Country?
death ritems	/ Fun	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?, 1	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
J036 urs after ural", o	ted by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates.  1 ☐ Yes 2 M No Specify:		Specify: Black
215-( n 72 hor s. Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	ucation le completed)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DQ NOT use retired)	king 161	b. Kind of Business Industry
land 212 be filed within ental Hygiene. ked other tha ic event, the I	Be Co	17. Father's Name (First, Middle, Last)	D Homemaker	ne (First, Middle, Maid	Own Home
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hyglene. 27 is marked other than "natural", o traumatic event, the Medical Exam	2	Walter B	Brown Dai	SV	Brown
Na 2 sh Ith an 27 is trau		19a. Informant's Name/Relationship (Typ	Reid Surphter 19b. Mailing Address (Street and Number or Rur	ral Rou Number, Cit St. Ba	y or Town, State, Zip Code)
		20a. Method of Disposition  1 Description   2 Description   3	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200 2010 I	c. Location - City or Town, State
Baltimo		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	e 22. Name and Address of Facility	- 1	Home, P.A.
<b>.</b>		23a. Part 1. Enter the disease, or compl	cations that caused the death. Do not enter the mode of dying, such as cardiac	ve. Balt	D. Ma. 21216 Approximate
Physician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each line.  HEART FAILURE		Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consequence of):		
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		
be executed be executed sician and burial-transi	al Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):		
760 cate be physic s the bu	edical		l		
ords, P.O. Box 68760  requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year
s that th	þ		ntributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the cause of death?
require require been si	leted	CORONARY ARTO		1 ∐ Yes 24a. Was an	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
N ≥ 85 S	Completed	NYRATENSION DEMONTIA		autopsy performed	prior to completion of cause of death?
Ital sician; certific rector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Checospital: Other: Other:	. /	
Of V ig Phys ter this heral di	te: To	27. Manner of Death	1  Inpatient 2  ER/Outpatient 3  DOA 4 Nursing H	ome 5 P Residence 28d. Describe how in	e 6 Other (Specify)  njury occurred
SION Attendir death. ctor; Aff y the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) Injury work?  1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office	29f Location (Street	and Number or Rural Route Number,
DIVIS intal or / urs after ral Dire		4 ☐ Homicide determined	building, etc. <i>(Specify)</i>	City or Town, St	fate)
DIVISION Of VITAI HEC  To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page.	Medical	(Check 2 L Medical Examin	cian: To the best of my knowledge, death occured at the time, date and place, and er: On the basis of examination and/or investigation, in my opinion, death occurred at Practioner: To the best of my knowledge, death occurred at the time, date and plate.	at the time, date and pl	ace, and due to the cause(s) and manner stated.
To the virth common com	_	29b. Signature and title of certifier	29c. License number  R 165 775		Date signed (Month, Day, Year)
lv		_ /	mpleted cause of death (item 23a) (Type, Print)		110010
Sta	te	31. Date filed (Month, Day, Year)	LENUC 900 CH TON AVE BALTIN	YORC 1	perie an
Registr		SEP 1 0 2010 - A	32. Registrar's Signature		

DHMH 17 Rev 7/2009

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Dav 130 P M **Physician** Mary Margaret Myers ptember 8,2010 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Months Days Hours Min 1 □ M 2 🔀 F 83 223 36 8852 Director June 28, 1927 Tennessee Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Inportant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modesi Experiment must be notified at once. Maryland Harford Edgewood 1 ☐Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1966 Chipper Drive 21040 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 14. Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Ye ar or Dates: 1 ☐ Yes 2 X No Specify. ģ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winfred Carl Young Virginia Elaine Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Saffa (Daughter) 107 Fitz Court Unit T4 Reisterstown, Maryland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 9/11/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home\_P.A. e 6 Funeral Service Licensee W 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Vements **Physician** /Medical Examiner Wynsin) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of: Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Mamic Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy

| Live birth | 2 | Fetal death | Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 

Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yeş⁄ 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this After thi 27. May er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes hours after death 2 Accident Director: 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hours the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID 9 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

SEP 1 0 2010

ORIGINAL

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amend item 26 per doc 9907 9-10-10 vt
State of Maryland / Department of Health and Mental Hygiene amend #1&5 Per FH G907 Ceftificate of Death State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death John Edward Mooney John Edward Mooney Physician/ 4,2010 11:04PM SEPTEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE MEDICAL CENTER <u>TOWSON</u> REATER S217-24-11793 216-28-1592 Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min May 29 Year 930 **Director** Baltimore, Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State Maryland Ob. County **Baltimore** Oc. City, Town or Location
White Hall 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country?
United States permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be ronce. 19006 Tyson Road 21161 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) C+P Telephone Company Engineer Be 18. Mother's Name (First, Middle, Maiden Surname)
Marie Tolodziecki 17. Father's Name (First, Middle, Last) ပ Thomas H. Mooney 19a. Informant's Name/Relationship (Type, Print)
Mrs. Peggy Mooney (Spouse) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 19006 Tyson Road White Hall, Maryland 21161 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other Sept. 10,2010 Wiseburg Cemetery White Hall, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused shock, or heartfailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Due to (or as a Name and Address of Facility Evans Funeral Chapel & Cremation Services 16924 York Road Monkton, Maryland 21111 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Physician/ ABE Medical Due to (or as a consequence of): Examiner NARY Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No ó Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant
9 ☐ Unknown 1 Yes 2 p 9 Unknown cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 this certificate has 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital 2 ☐ No မ 1 Tes 1 Inpatient 2 K ER/Outpatient -3 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After injury 1 Natural 5 Pending s after death. Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
1 Certifying Number Practioner: To the best of my knowledge death occurred at the hime, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASSETIST BMC 31. Date filed (Month, Day, Year) 2. Registrar's Sig State 1 0 2010 Registrar

MOONEY

	-	State Registrar		State of Ma	-	ertificate of		wentai ny	glene Reg. No.	010	28508
	7		ne (First, Middle, La	st)				2. Date of De		Year	3. Time of Death
hysiciaı /Medica	-	ROY	MILB	OURNE				SEP7	07	2010	1-309
Examine			(If not institution, giv	street and number)		4b. City, Town, o	r Location of Dea	ith	4c. C	County of Death	1
	8	Genesis	Multi Med	lical		Tows				Baltimo	
neral ector		5. Social Security 1	-7342	ex 7. Age 132 M 2 ☐ F 88	(In yrs. last birthd	Months Days	If Under 24 Hr. Hours Mir		29,19	9. Birth Cou Ma	nplace (State or Fore untry) ryland
		Usual Residence of 10a. State	of Decedent 10b. County		10c. City, Town o	r Location					10d. Inside City Lim
E Da	ŏ	MD	Balti	more	,,		unda1k				1 ☐ Yes 2
Distribution of the second	ect	10e. Street and Nu		inore		10f. Zip Code			10g, Citiz	en of What Co	untry?
3		1751	Stokesley	Road		21222	•		Un	ited St	ates
	Funeral Director	11. Marital Status		12. Was Decedent E	ver in U.S.	13. Was Decedent of H		Specify Yes or N	0- 1-	4. Race - Amer	
	by Fur		ried 2 Married	Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give Year or Dates:	o WWII	1 Yes 2 No		nto rican, etc.)		Black, White Specify:	White
	ted		15. Decedent's E		16a. De	ecedent's Usual Occup	pation			d of Business/l	
-	Completed	(Spe Elementary/Sec	ondary (0-12)	College (1-4or 5-	+) (G	ive kind of work done te. DO NOT use retire	during most of w d)	orking		hlehem	Steel
1	Ö	12 Yea				Engineer			Rai	1road	···
	Be (	17. Father's Name	(First, Middle, Last,					ame (First, Middle		Sumame)	
	၉	Roy W.	Milbourne	2			Hilda	G. Park	s		
other traumatic evant, the Modical Exertities is used for notified at			Name/Relationship ( nald Milbo	Type, Print) Durne (Son)		ailing Address <i>(Street</i> 501 Double	Rock La	Ru <i>ral R</i> ou <i>te Numt</i> ne Park	oer, City or Ville	Town, State, Z	(ip Code) 21234
		20a. Method of Dis	,	3D	cemetery,	isposition (Name of crematory or other pla	ce)	Date	20c. Loc	cation - City or	Town, State
once.			5 ☐ Other (Specif	Removal from State y)	Gardens	of Faith	Cem. 9/	13/2010	Bal	timore,	, Maryland
once.		21. Signature of	un ful Service Lice	1500		22 Name and Addre	ss of Facility	1 Home o	f Dun	dalk, I	Inc.
а		1/0	1 del	-11111	1	7922 Wise					1222
		23a. Panty. Enter	the disease, or com art failure. List only	plications that caused one cause on each lin	the death. Do not	enter the mode of dyi	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
an		Immediate Cause disease or conditi	(Final	a COL or		NCER					Monute
cal		resulting in death)			consequence of):						
ner	U	Sequentially list of	onditions.	b							
Duriat-transit	ner	Sequentially list of any, leading to it cause. Enter Und	immediate tertying	Due to (or as a	a consequence of):					1	
	Examiner	that initiated even resulting in death)	ts	C	a consequence of):						
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Due to (or as a	s consequence or).						
	cal			d							
:	ᇴ										
:	/Medi	IF FEMALE:	et prognat	23c. If yes, outcome	of pregnancy				2	3d. Date of deli	iverv
	cian/Med	23b. Was decede in the past 12	2 months?	23c. If yes, outcome of 1 Live birth 4 Pregnant at	2 Fetal death	3 Ectopic pregnanc 5 Other (specify)	у		2	3d. Date of deli Month	ivery Day Year
	nysician/Med	23b. Was decede	2 months?	1 Live birth :	2 Fetal death		у		2		,
or use as me	Physician/M	23b. Was decede in the past 12 1 Yes 2 9 Unknow	2 months?	1☐Live birth : 4☐Pregnant at	2 Fetal death time of death	5 Other (specify)		23e. Did		Month	,
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pletely filled in by the funeral director, page 2 should be detached for use as the	Medical Certification: To Be Completed by Physician/M	23b. Was decede in the past 1: 1   Yes 2   9   Unknow Part II. Other sign C   6   6   6   25. Was case reference examiner? 1   Yes 2   27. Manner of Dea   2   Accident   3   Suicide   4   Homicide   29a. Certifier (Check only one) 29b. Signature an   6   6   6   6   30. Name and add	2 months?  No n  ifficant conditions of the cond	Hospital: 1   Inpatier  28a. Date of Injur (Month, Day building, etc.)  28e. Place of Injur building, etc.	at not resulting in the control of my knowledge, control of my knowledg	atient 3 DOA Ottor (specify)	26. Place of D her: Nursing ry at rk? ) Yes 2 \[ \] No	24a. Wa auturper 1 Yes eath (Check only Home 5 Res 28d. Describe 28f. Location City or Toured at the times	tobacco us Yes 2 s an opsy formed? 2 no one) sidence 6 how injury (Street and own, State) a cause(s) , date and 29d. Date	Month  se contribute to  No 3 Pr.  24b. Were au prior to death? 1 Yes  6 Other (Specty occurred)  d Number or Ru  and manner as place, and due  e signed (Mont)	Day Year  othe cause of death?  obably 4 UHINNO  atopsy findings availabompletion of cause 2 No  cify)  aral Route Number,  a stated.  o to the cause(s)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of N	Maryland	•	artment of F		and Me	ntal Hyg	giene	20507
		_	Registrar  1. Decedent's Name (First, Middle, L	act)		Cer	tificate of L	Jeatri	1.0		Reg. No. U U	20001
	Physicia		Carol Lee Mille	•						. Date of Dear Month eptember	Day Year	3. Time of Death  10:40 A M
	Medic Examin		4a. Facility Name (if not institution, g	ive street and number	)		4b. City, Town, or	r Location of		-pediber	4c. County of Dea	
	<i>*</i>		4304 Elizabeth				Rockvi				Montgome	
	Funeral Director			. Sex 7. A 1 □ M 2 汉 F	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min	Date of Birth (Month, Day,	Vear) Co	rthplace (State or Foreign ountry)
			219-86-0240 Usual Residence of Decedent		48	110.				ecember	16, 1961[Was	shington, D.C.
	land show	ţō	10a. State 10b. County		10c. City, T	own or Loc	cation					10d. Inside City Limits
	Mary 28a-1 otifie	Director		gomery				kville	9			1 ☐ Yes 2 🗹 No
	th the 3a or t be n	alD	10e. Street and Number				10f. Zip Code	F 0			10g. Citizen of What C	
	ath w	Funeral	4304 Elizabeth S	12. Was Deceden	t Ever in LLS	13 V	208.		in? (Specify	/ Yes or No-	United Sta	
9	or ite	by F	1 ☐ Never Married 2 🏋 Married	Armed Forces	?		Vas Decedent of Hi Yes, specify Cuba		Puerto Ric	an, etc.)	Black, Whi	te, etc.
933	ırsaft ural", IExa	ted	3  Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 🗓 No	Specify:			Specify: Wh:	ite
21215-0036	72 hou "nat ledica	Completed	15. Decedent's (Specify only highest		1/1	(Give k	ent's Usual Occup		of working		16b. Kind of Business	s Industry
12	thin the constant of the const	Son	Elementary/Seconday (0-12)	College (1-4 o	r 5+)		O NOT use retired)  ager				Retail_	
9	lled w I Hygi other	Be	17. Father's Name (First, Middle, Las	t)		11411	agei	18. Mother	r's Name (F	irst, Middle, N	Maiden Surname)	
/lar	d be f Menta arked atic ev	유	James Clatterbuc	k				Herma	a Zeol	Li		
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	and Number	or Rural Ro	oute Number,	City or Town, State, Z	ip Code)
	and 2 Health em 27 ther to		David R. Miller/ 20a. Method of Disposition	Husband		4304	Elizabe	th Str			ille, Mary	
Baltimore,	permit. Page 1 and Department of Hamportant; If ite any injury or ot once.		1 Burial 2 X Cremation 3		te Mont	e of Dispo: etery crem <b>goine r</b>	sition (Name of natory or other place	e) Se	ptembe	r8,	20c. Location - City o	
Ē	nit. Pa artme ortan injury		4 Donation 5 Other (Spe 21. Signatur of Funeral Serving Lic-		Crem	<u>atori</u>	um, Inc.		2010		Bethesda,	
Ba	permi Depar Impor any ir		flain 11.	hoda	M01530	0 30	bert A. O West Mo	Pumphr ontgom	rey Fu nery <i>E</i>	neral Ave., I	Home, Rock Rockville,	kville, Inc. MD 20850
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	emplications that caus y one cause on each li	ed the death. Dine.	o not ente	r the mode of dying	g, such as ca	ardiac or re	spiratory arre	est,	Approximate Interval Between
4	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		sis							Onset and Death
200	Examiner			(h	s a consequence		r					Months
		iner	Sequentially list conditions, if any, leading to immediate	υ. —	s a consequen		L					Months
9.	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or imjury that initiated events	c							3	
٥,	ate be executed physician and the burial-transit	al E	resulting in death) Last	Due to (or a	s a consequen	ce of):						
200	physic the b	edical		d								
687	eath certificate be attending physion of for use as the k	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy	,					23d. Date of de	alivery
Box	eath of atter	icia	in the past 12 months? 1 ☐ Yes 2 💢 No	4 ☐ Pregnant	at time of deat	eath 3∟ th 5□	Ectopic pregnanc Other (specify)	У			Month	Day Year
O.E	t the de by the stached	hys	9 Unknown	9 📙 Unknowr					_			
, P.O.	es that signed l be det		Part II. Other significant conditions	contributing to death	i but not resultii	ng in the u	nderlying cause giv	en in Part I.			pacco use contribute to	
rds	v requires been sig should b	eted	Paraplegia						}			Probably 4 Unknown
၀၁	has b	Completed by								24a. Was ar autops perforr	sy prior to	utopsy findings available completion of cause of
Ä	n: The la fficate ha or, page		25. Was case referred to medical				ne pu	ace of Death	/Chank an	1 Yes	2 🗓 No 1 ☐ Ye	s 2 🗆 No
Vita	iysician: is certific director,	To Be	examiner? 1 X Yes 2 ☐ No	Hospital:	atient 2 🗆 ER	/Outnatien	Othe	DF.		,	ence 6  Other (Spec	cifu)
of	ng Ph ter thi neral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of in (Month, D	jury 28	b. Time of injury	28c. Injury work	at at			w injury occurred	snyy
ion	tendii leath. tor; Ai the fu	ifica	2 Accident Investigat 3 Suicide 6 Could no	ion			M 1 □	Yes 2 N	No			
Division of Vital Records,	or At after o	Certificate:	4 Homicide determine	28e. Place of Ir	njury - At home etc. (Specify)	, farm, stre	et, factory, office		28f.	Location (Sta City or Town	reet and Number or Ru , State)	ural Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 X Certifying PI	nysician: To the best of	of my knowledo	ge, death o	ccured at the time.	date and pla	lace, and di	ue to the caus	se(s) and manner as st	ated.
	he Ho in 24 I he Ful pletec	Medical	(Check 2 L Medical Exa	miner: On the basis of	examination an	d/or investi	gation, in my opinio	n, death occu	urred at the	time, date an	d place, and due to the cause(s) and manner as	cause(s) and manner stated.
	To the I		29b. Signature and title of certifier	Wan	m a	/	29c. License	number		2	9d. Date signed (Mont	h, Day, Year)
	^		kenn	TIVE	-///N		D340	)32			September	7, 2010
	12		30. Name and address of person who					7 •	- 4		1 00005	0010
	Stat	e	Jeanne P. Asher,	32. Regis	trans Signature	igut	avenue, k	ensin	igton,	Maryl	and 20895-	-2210
	Registra	_	SEP 1 0 2010	Deneur,	trans Signature	LANGE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR G907 9/10/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day August 7, 2010 RAY MOND MCCLELCAN 8:00 PM M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bayridge Nursing Home Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F unk 70 Oct 7, 578-52-4557 1939 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4310 Jefferson Street #2 20781 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? unk 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 2 No unk 1 ☐ Yes 2 🗓 No Specify. white Specify: 3 Widowed 4 Divorced CHIEF. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bayridge Nursing Home 900 Van Buren Street Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Overgation 3 Removal from State 4□Donation 5♥Other (Specify) in state 21. Signature of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Altrecorderchi Cardiovas culor Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner Examiner be executed burial-tran P.O. Box 68760. the as

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be ပ unk

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician use for signed by the a cate has been sig page 2 should b certificate

Physician/Medical ģ Completed funeral director, Be P After this he Hospitai or Attending PI n 24 hours after death. he Funerai Director; After the pletely filled in by the funeral Certification: Medical

Division or Vital Records,

1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certif

29a. Certifier

2006368

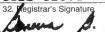
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ajit Kurup, 1808 Carters Grove Dr. Silver Spring ,MD 20904-6625

State Registrar

31. Date filed (Month, Day, Year)



To the I within 24

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	•	epartment of Health and M Certificate of Death	Reg. No	2010 20500
	Physicia Medic		1. Decedent's Name (First, Middle, Florg Mac	Lyst) Lurphy		2. Date of Death	Year 3. Time of Death 3.58 AM
	Examin		4a Facility Name (if not institution,	give street and humber)	4b. City, Town, or Location of Death		County of Death
	Funeral Director		5. Social Security Number 220-20-1924	6. Sex 1 M 2 G F 7. Age (In yrs. last birting	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month Day Year)	9. Birthplace (State or Foreign Country)
	faryland 3a-f show tified at	ector	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town o	or Location FIMORE		10d. Inside City Limits 1 Yes 2 □ No
	with the N is 23a or 28 nust be not	Funeral Director	106 Street and Number 106 KiChU	rood Avenue	10f. Zip Code 2/2/2	10g. Ci	tizen of What Country?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 💢 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates.	<ul> <li>13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F</li> <li>1 Yes 2 No Specify:</li> </ul>	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	vithin 72 hou jiene. er than "nat the Medica	Completed by	15. Deceden (Specify only higher Elementary/Seconday (0-12)	t grade completed) (0	ecedent's Usual Occupation The kind of work done during most of working The DO NOT use retired The DO MUSHIC	ig .	Onest (
yland;	ild be filed v Mental Hyg harked other	To Be	17. Father's Name (First, Middle, La EUGINE Law	ist) Vrence	1 1	(First, Middle, Maiden Mae Mc U	Surname)
e, Mar	and 2 should Health and M tem 27 is mai	117	19a, Informant's Name/Relationsh  Phyll 5 Lucen  20a, Method of Disposition	Daughter 67	Mailing Address (Street and Number or Rural  HOWAIT Drive G  Disposition (Name of	kn Burni	r Town, State, Zip Code)  e, Maryland 21061  ocation - City or Town, State
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		1 Burial 2 ☐ Cremation 4 Donation 5 ☐ Other Si 21. Si nature of Funeral Service	3 ☐ Removal from State Ceametery,	crematory or other place)  22. Name and Address of Facility	110 Ba	Not Road
ĕ	Depa Impo any ii	0	230 Part Enter the diseased are	complications that caused the death. Do not	Vaughn C Greene F.	2. Raiti	More, Maryland 21212
1	Physician/ Medical Examiner		sheck, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	aa	cardion yopat	nespiratory arrest,	proximate Interval Between Onset and Death
£.		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Luc to (or as a consequence of)	,		
900	fficate be executed g physician and as the burial-transit	lical Exa	that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1  Live Birth 2 Fetal death 4  Pregnant at time of death 9  Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
ls, P.O.	uires that the signed by ald be detact	by	200	rs contributing to death but not resulting in the New School			use contribute to the cause of death?
Division of Vital Records,	The law req ate has bee page 2 sho	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  o 1 □ Yes 2 □ No
Vital	ysician: s certific director,	To Be (	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	26. Place of Death (Check		Stather (Specify) NOS prie
n of	ding Phy h. After thi funeral o		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of injury 28b. Tim (Month, Day, Year) inju	ne of 28c. Injury at 2	8d. Describe how injur	
Divisio	al or Atten s after deal il Director: ed in by the	l Certificate:	2 ← Accident Investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ot be		l8f. Location (Street an City or Town, State	d Number or Rural Route Number, )
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 Medical Exposure) 3 Continuing	Physician: To the best of my knowledge, de caminer: On the basis of examination and/or in Nurse Frectioner: To the bast of my knowled	nvestigation, in my opinion, death occurred at tige, death sociumed at the time, date and place	the time, date and place , and due to the couse(	e, and due to the cause(s) and manner stated.
	No.		29b. Signature and title of certifier	Um.	29c. License number		resigned (Month, Day, Year)
	5		C narry	ho completed cause of death (Item 23a) (Type Months of Control of	pe, Print)		
ST.	Stat Registra	e	31. Date filed (Month, Day, Year) <b>SEP 10 20</b> 1	32. Registrar's Signature	ald		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 <u>James Martin Nay</u> Medical <u>September</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fallston Harford 1300 Fallston Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, April 9, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1**X** M 2 □ F West Virginia Yrs Director 67 214-40-3157 April Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Harford Fallston 1 Yes 2 X No Md. 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 1300 Fallston Road 21047 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinance. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Completed | 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry United States (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Supervisor Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert W. Nay Letty Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca E. Nay Spouse 1300 Fallston Road Fallston, Md. 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 9/9/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitSchimunek Funeral Home of Bel Air 610 W MacPhail Road Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ meromeriona disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 2 No 9 Unknown 9 I Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 📈 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 10057936 09-09-2010 - nuo

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Manuel Lus

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HECHTNEY D. MCHNUCI LUD 225 GYELNE ST. BOUTHNEYE MID 21201.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9 2010 SHARON E. NOHE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore FRANKLIN SQUARE HOSPITAL CENTER Rosedale Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 👿 F 62 Maryland 212-50-6152 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b, County 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, it is Modical Exercises must be notified at 1 ☐ Yes 2 No Baltimore County Director Maryland | Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21237 9130 Philadelphia Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes YNO Specify: 3 ☐ Widowed 4XXDivorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, it is Mode. once. (Specify only highest grade completed) 12 yrs. College (1-4or 5+) N.S.A. Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annette Mae Toboll Louis Adam Dohler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9148 Lennings Lane Baltimore, Md. 21237 Carole L. Krach(Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 9-11-2010 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 17401 Belair Rd. Baltimore, Md. 21. Figure of Funeral Service Licensee MCD+tree 10050th 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SEPSI /Medical Due to (or as a consequence of): Renal Failure Examiner END STage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine HyperTension
Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, $\overset{\sim}{\sim}$ SYNDROME Physician/Medical Goodpastures 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>δ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier STEPTEMBER, 9, 2010 Wolfartil D69193 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

John V Kottarathil good FRANKLIN Square DR Balto md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b perFH. G907, 9/10/2010 WS
State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0.35 M Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner SPIC 0 8. Date of Birth (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 Months Days Hours Min Director Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Director Anne Arundel 1 X Yes 2 No Inne Arua 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Completed 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name Delationship (Type, Print) (daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place 1 X Burial 2 Cremation 3 Removal from State 12010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Faci Joseph — Fr 2222 W. North 21. Signature of Funeral Service Licensee 23a. Part J. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) Pregnant at time of death signed by the at d be detached fo g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ♣ nknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy After this certificate has Ves 2 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? 2 🗀 🖧 Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 the (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending n 24 hours after death.

le Funeral Director: After political in by the fun 2 | No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Wertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2 To the P only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) completed cause of death (Item 23a) (Type, Pkint) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 0 | 0 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Monteptember 6, 2010 Joseph Anthony Pursley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 354 Rambling Ridge Ct. Anne Arundel Pasadena Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 68 Months Days Hours Min. 1 M 2 🗆 F (Month Pay2 Year) Maryland 212-38-4244 1942 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 354 Rambling Ridge Ct. 21122 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Commercial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Jessie Curtis Pursley Yowell Frances 19a. Informant's Name/Relationship (Type, Print)

Denise Pursley /Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 354 Rambling Ridge Ct. Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 09 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Alternatives MO1585 Reboc Hock 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Onset and Death Immediate Cause (Final ance Physician/ disease or condition resulting in death) Medical Due to (or as a co is quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown for 5 Other (specify) Year Pregnant at time of death Month Day signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 🔲 Yes 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) September 8, 2010 29b. Signature and title of certifier 29c. License number D39505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yudhish Markan 305 Hospital

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 0 2010

32. Registrar's

Dr. Glen Sumie, MD. 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month September 5, 1:15 PM 2010 Jessie H. Packett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 X F 92 (Month, Days Year) 1918 226-09-9925 <sup>C</sup>Marvland Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits with the Maryland Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified MD 1 Yes 2 No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3522 Hiss Avenue 21234 United States · death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 filed within 72 hours after Yes 2 NO If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify White 3 - Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mollie Gardner B. Hillyard Haines permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Hofmeister /Nephew 2647 Shepperd Road Monkton, MD 21111 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State <sup>Date</sup>Sep 09 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Winchester, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hebron Cemetery 2010 22. Name and Address of Facility Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 93 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached g 🗌 Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 🗘 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniun work?
1 Yes 2 No 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🖂 To the within 2 To the P only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day,

0 2010

TOW SON M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 0 285 | 5 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		Registrar			ertifica	ale oi	Deam				F	Reg. No.			
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle Michelle Monelle	Marie — Marie		Petti Petti	_				:	Date of Dea Month Septemb	Day er 6, 20			3. Time of Death 0046 hrs
		4a. Facility Name (if not institution 118 Washington Blvd.		umber)		4	b. City, Tow Laurel	n, or L	ocation of	Death			County of E		S
Funeral Director		5. Social Security Number 220-04-1832	6. Sex	7. Age (In y		hday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24Hrs. 8 Min.	8. Date of B	`	F	oreign	place (State or ntry) DC.
	- 1	Usual Residence of Decedent					<u> </u>			<u> </u>	1100	,	2000		
any	ı	10a. State 10b. County		10c. (	City, Town	or Location	on							$\top$	10d. Inside City Limits
≥	_	DE Susse	ex	M:	illsb	oro									1 Yes 2 X No
daryland 28a-f show 1 at once.	윓	10e. Street and Number					10f. Zip Co	ode				10g. Citize	en of What	Count	ry?
10re, MD 21215-0036 gas 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	Il Director	429 Tunbridge					1996						ed St		
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r dea	교		1 Yes	2 X N	0		V 0 TT	1					Specify: V	Jhi	t o
rs after	ē	3 Widowed 4 X Div	orced If Yes, Give Ye or Dates:	de completer	1) 16a I		Yes 2 X 's Usual Oc			nd of wor	k done		nd of Busin		
2 hour	ompleted	Elementary/Secondary (0-12)		1-4 or 5+)			st of workin					100.10	id of Edoin	000/111	ddolly
136 hin 72 ho e. than "na tdical Ex	죑	1.0	,	,	A	CCOIII	ntant					Co	nstru	ict	ion
d with	ě	17. Father's Name (First, Middle,	Last)			-	ii caii c	18	3.Mother's	Name (F	irst, Middle,				
21215-0C uld be filed wi Mental Hygien marked other c event, the M	BeC	n . 1. W. Pe	ettit					١	Brend	a Ho	dges				
21. 21. Men mar c eve	2	Franklin W. Pe	hip (Type, Print )		19b	o. Mailing	Address (				al Route Nu	mber, City	or Town,	State,	Zip Code)
ore, MD 21215-0036 yes I and 2 should be filed within 7 of Heath and Mental Hygiene. If item 27 is marked other than ther traumatic event, the Medical		Brenda Klinger	abiel	(mother	r) 4	29 T	unbri	ige	Ct.	Mill	sboro	, DE.	1996	56	
ore, MEss 1 and 2 s of Health as If item 27 her traums		20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal fi	1		of Disposit	tion (Name	of cem	etery,	Sept	ate 9	20c. Lc	ocation - Ci	ty or T	own, State
Pages ent of		4 Donation 5 Other SA				•	e Cre	nato	- 1	20		Be1	tsvil	l1e	, MD
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr	1	21 Signature of Foneral Service		1			ame and Ad								
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Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the de	ath. Do no	ot enter the	e mode of d	ying, s	uch as car	diac or re	espiratory ar	rest, shoc	k, or heart		Approximate Interval Between Onset and
/Medical ≞xaminer		Immediate Cause (Final disease	a. Compl	licati	ons o	f ch	ronic	alo	coho1	abu	se				Death
		or condition resulting in death)	Due to (or as	consequenc	ce of):										
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8760, tificate be ng physic as the bur	ě	IF FEMALE:	23c. If yes,	outcome of p	regnancy	,500	10/4/		_			23d.	Date of de	livery	
687 certific ding		23b. Was decedent pregnant in the past 12 months?	I LIVE I	oirth nant at time o	f doath	Feta		3	Ectopic p	oregnancy	У	M	/lonth	Da	y Year
Box 6: death cert the attendired for use a	Physicia	1 Yes 2 No 9 V Unk	known 9 Unkn		5	Oth	er (Specify,	)							
D. B.	된	Part II. Other significant conditi			ot resulting	g in the ur	nderlying ca	use giv	en in Part	L	23e. Did t	obacco us	se contribu	te to th	e cause of death?
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should!	ertification	1 Natural 5 Pend	28a. Date (Month	ı, Day,Year)		•			s 2 N						
ivisior  or Attend after death Director:	g	2 Accident Inves	stigation 28e Plan	e of Injury - A	At home, fa	ırm, street	, factory, of	fice bui	ilding, etc.	28	f. Location (	Street and	d Number o	or Rura	al Route Number, City
Division pital or Attent ours after death first Director:	팋		d not be mined (Specify)								or Town,	State)			
Di Hospital 24 hours s Funeral etely filled	0	20a Cartifier	nysician: To the be	st of my know	rledge, dea	ath occume	ed at the tim	ne, date	and place	e, and du	e to the cau	se(s) and	manner as	stated	I.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical	one) 2 Medical Exa	miner:On the basis and manners	of examination	on and/or in	nvestigatio	on, in my op	inion, d	death occu	irred at th	e time, date	and place	e, and due	to the	cause(s)
F. W. F. S.	Me	29b. Signature and title of certifie		nated.			29c. Li	cense	number			29d. Da	ate signed	(Mont	h, Day, Year)
		Lowof Frank	holl nes				C	C.M	.E.			Septe	ember 6	, 201	0
_		30. Name and address of person	who completed cau	se of death (I	tem 23a)							<u></u>			
		Pamela E. Southall, M	ID Assistant	Medical E	xamine	r 111	Penn St	reet,	Baltimo	re, MD	21201				
	C.C.	31. Date filed (Month, Day, Year)	32. R	egistrar's Sig	ature	arke	1		-						
Regist	rar	SEP 1.0.20	10 LAMEN	A P	. 19	M. A.									

		Please Type of State 1 - For State Registrar	of Maryland / De		lealth and M	lental Hyg		28516
		Decedent's Name (First, Middle, Last)				2. Date of Dea	ith	3. Time of Death
Physici		Andrew J. Poffe	1			Septemb	er 06 2010	10:31 a <sup>M</sup>
/Medic Examin		4a. Fecility Name (If not institution, give street and r	umber)	4b. City, Town, o	Location of Death		4c. County of Dee	th
		7825 Chelsea St.	.,	Towsor			Baltimo	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth:	Months Days	Hours Min.	8. Date of Birth (Month, Dey	9. Bir	thplace (State or Foreign
Director		Usual Residence of Decedent	66 Yr	3.		Feb. 25	, 1944 Mar	yranu
land wo		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Many P-f sh	ţo	Md. Baltimore	Towson					1 ☐ Yes 2 🔀 No
th the or 28a	ire	10e. Street and Number		10f, Zip Code			10g. Citizen of What Co	
ath wi	Funeral Director	7825 Chelsea St.		2120				USA
er de de la composition della	nne	Armed	ecedent Ever in U.S. Forces?	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (Spann, Mexican, Puerto	acify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
rs afte	by F	1 Never Married 2 Married 1 Yes	s 2 🔯 No Give	1 ☐ Yes 2 🕱 No	Specify:		Specify:	White
2 hou		15. Decedent's Education	16a D	Decedent's Usual Occup	ation		16b. Kind of Business	/Industry
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ad with	Completed	+1	4 Pr	esident			Land Deve	lopment
be filk tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
ould Men narke	2	Andrew E. Poffel			Josephi			Zin Code)
12 sh h and 7 Is n traun		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street				ZIP Code)
1 and Healt em 2		Mrs. Diane Poffel/ Wife  20a. Method of Disposition	20b. Place of D	25 Chelsea Disposition (Name of		Date	20c. Location - City or	Town, State
ages nt of t: If it		1 X Burial 2 ☐ Cremation 3 ☐ Removal fro		crematory or other place idge Cemete		·10	Pikesvill	e. Md.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ODEs.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Suner Service Ucensee)	7		3	_		
permi Depa Impo any is		1 1.12		22. Name and Addre RUC 10F	ck lowson 30 York Ro	Funeraı İ. Towso	Home, Inc on, Md. 212	<b>0</b> 4
		23a. Part1. Enter the disease, or complications that shock, or heart failure. Vist only one cause or	t caused the death. Do no					Approximate Interval Between
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/Medical		resulting in death)	o (or as a consequence of	):				
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wrequires that the death certificate be execu been signed by the attending physician and should be detached for use as the burial-tra	Physician/Medica	- U						
h cert andin	In/M	230. was decedent pregnant	outcome of pregnancy	3 □Ectopic pregnancy	1		23d. Date of de	
death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pre	gnant at time of death	5 ☐ Other (specify) _			Month	Day Year
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Atternation description by the	ifica	3 Suicide 6 Could not be 2 Pla	ice of Injury - At home, farr			28f. Location (S	Street and Number or F vn. State) 7825 C	Pural Route Number,
tal or rs afte al Dir	Certification;	Thomas Su	Hama	2		Towson	Md 212	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Physicien: To (Check only 2 Medical Examiner: On the						
the F hin 24 the F nplete	Medi	one) and m	anner stated.					
with To	2	29b. Signature and title of certifier	1	29c. Licens			29d. Date signed (Mor	
		The Will to MI Das			667	3	petember	1,2010
101		30. Name and address of person who completed of Philip Military Military No. 12 (1)	le Trimble H	ype, Print)	a lle i	1270	0.3	
Sta	ate	31. Date filed (Month, Day, Year) 32	Figistrar's Signature	- A-	010.116	10 210		
Regist		SEP 1 0 2010	Burns A	March !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 2851 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sharon Pack 21:53 2010 ququit Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital Harbor Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days Min. **Director** Yrs 212-84-6095 Dec 26, 1961 Maryland Usual Residence of 28a-f shov 10a. State 10b. County ms 23a or 28a-f shormust be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 213 Berlin Avenue 21225 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by ō 1 X Never Married 2 Married Yes 2 No Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Black Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Anne Arundel County Gov. Permit Tech Be 17. Father's Name (First, Middle, Last) and Mental F 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Pack Marie Pack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 213 Berlin Avenue Baltimore, Maryland 21225 Kysha Naylor item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ± 5 Department of Importants If any injury or 5 Other (Specify) 09/07/10 Severna Park, Maryland Carpenter Hill 21. Signature Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A d the death. Do not enter the many and a large Balling and a 1217 1. Enter the isease, or complications that cau k or failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Coronery Artero Medical Due to (or as a consequence of): Examiner years Atherosclerosis Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year Day 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Heart Failure Division of Vital Records, Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Hyperlipidemis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Duschthymia perform ordiac Yes Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at I Director; After to in by the funeral 28d. Describe how injury occurred 1 📈 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an 29d. Date signed (Month, Day, Year) D68793 veryour 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Harbor

32. Registrar's Signati

Stevenson

Xaren
31. Date filed (Month, Day

Hospital

3001 Hanover St. Baltimore, MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

lichael Proios		St For State egistrar	ate of Maryla		artment o			Menta	al Hy		2 0 eg. No.	10	28518
Physician Medical Examine	1	Decedent's Name (First, Middl Michael Pro								Date of Dea Month September	th Day Yes		3. Time of Death 1656 hrs
		la. Facility Name (if not institutio		ımber)		4b. City, To		ocation of		ООРКОПІВС	4c. County	of Death	
Funeral Director		34-46-3755	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under Months	_	If Under: Hours	1.11	8. Date of Bi		Cou	nplace (State or Foreign ntry) STEECE
ryland a-f show any fonce.	1	Journal Residence of Decedent Oa. State 10b. County MD			Town or Locate		ty						10d. Inside City Limits 1 X Yes 2 No
uth the Maryland 23a or 28a-f sho notified at once.		Oe. Street and Number	venue	· ·		10f. Zip (	224				0g. Citizen of WI	nat Count	try?
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	runerai	1. Marital Status 1. Never Married 2. 4. Div		2 No	If Y	as Deceder es, specify	Cuban, I	Mexican, F		cify Yes or No lican, etc.)		e, etc.	an Indian, Black,
5-0036 ed within 72 hours a eygiene. other than "natura the Medical Exami	mpieted b	15. Decedent's Education (Spe Elementary/Secondary (0-12)			-	nt's Usual C nost of work	ing life. D	no NoT us	se retire	d)		port	cation
e, MD 21215-0036  1 and 2 should be filed within 72  Health and Mental Hygene.  Filem 27 is marked other than "  To Ro Commiss  To Ro Commiss	8	7. Father's Name (First, Middle, Markos Proide) 9a. Informant's Name/Relations	os		19b. Mailin	g Address		Sop	hia	Pate			Zip Code)
e, MD 2  l and 2 shou  Health and I  item 27 is r  traumatic	_ N	9a. Informant's Name/Relations Nora Kefalas- 20a. Method of Disposition	Persón Repres	al entati	ve 520	S.	Pone	ca S	t.,	Balt	imore,	MD - City or	21224
	1	1 ABurial 2 Cremation 4 Donation 5 Other Sp		om State	<ul> <li>Deme</li> </ul>	her place)	s C	em		-10	Balti	•	
Baltimor permit. Pages Department of Important: If	K	21. Size ture of Funeral S. wice.	$\rightarrow$		21		ille	ow S	pri	ng Ro	ad, 21	222	neral Home
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause immediate Cause (Final disease	on each line. a. Atheroscle	rotic Cardiov	ascular Dis		dying, sı	uch as car	diac or	respiratory ar	rest, shock, or he	art	Approximate Interval Between Onset and Death
/		or condition resulting in death) Sequentially list conditions,	b	a consequence o									
ted Insit	xamine	f any, leading to immediate rous Frit r this thing Cruss (Disease or injury that initiated events resulting in death) Last	С	a consequence o									
0,  e be executed  vsician and  burial - transit	- G	UNPENDED	d AMENDED										
	/sician/me	F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unit	he 1 Live t	nant at time of de	2 Fe	etal death ther (Spec		Ectopic p	oregnan	су	23d. Date of Month		ay Year
P.O. Barres that the designed by the be detached	2	Part II. Other significant condit		o death but not r	esulting in the	underlying	cause giv	en in Part	i I.				he cause of death?
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedievel of or the physician of the	Complete									1 Yes	psy orm <u>ed</u> ?		opsy findings available ompletion of cause of s 2 No
f Vital Physician: or this certificated director	මු   <sup>2</sup>	25. Was case referred to medica examiner?  1 ✓ Yes 2 No	Heavitel -	Inpatient 2	ER/Outpatien		10	of Death (Cother			Residence 6	<b>✓</b> Other	Scene
ion of literating the form of the funeral		27. Manner of Death  1  Natural 5 Pene		of Injury h, Day,Year)	28b. Time of	Injury 2		at Work?	No		how injury occur		
Divis  Bospital or At Hospital or At Puneral Direc tely filled in by		3 Suicide 6 Cou 4 Homicide dete	ld not be 28e. Place (Specify)							or Town,	State)		al Route Number, City
To the Ho within 24 P To the Fu completely	<u> </u>		hysician: To the be aminer:On the basis and manner:	of examination a									
H 3 H 5	N Z	29b. Signature and title of certific		N	1	290	O.C.M				29d. Date sign Septembe		
	3	30. Name and address of person Zabiullah Ali, M.D.	Assistant Medic	/		nn Stree	t, Baltir	nore, M	D 212	01			
Stat Registra	te <sup>3</sup>	31. Date filed (Month, Day Year)	0 2010 32.R	ed strar's Signat	ure A.	face	1			_			

State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death PIN 2150 M Physician/ Medical 4a. Facility Name in not institution, give street and number 4b, City, Town, or Location of Death 4c. County of Death Examiner AUX . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day, eb 5 1 Director 578-52-9919 Feb New Jersev Usual Residence of Decedent or 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Anne Arundel Laurel 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ll Paula Street South 20725 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes ※XX No Specify: Specify: White "natural" Completed 3 ₩Widowed 4 □ Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Lab Manager Medical Research permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George Thomas Olson Sylvia Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Dunaway / son 15250 Letcher Road Brandywine, Maryland 20613 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometer, crematory or other place)
Maryland Veterans Cem Sep 13 2010 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donaldson Funeral 313 Talbott Ave, Home, P.A. Laurei Maryland 20707 M01581 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final terioscleratie 1SEAS-R Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death g Unknown Records, P.O. is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina s after death.

I Director: Aff
d in by the fur Accident Investigation 3 Suicide 4 Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) put 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 ne and address of person who completed of death (Item 23a) (Type, Print) ONES . Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen Perry September8 2010 4:05  $p^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2281 Pentland Drive Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/25/195 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 **X** M 2 □ F Months 217-68-1430 52 Yrs **Director** MD Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore MD 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral 2281 Pentland Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced Specify. Black permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Exponee. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Shirley A. Kelsic James H. Winters 19a. Informant's Name/Relationship (Type, Print)

Jennifer Foy/Daughter 19b. Mailing Address (Street a 4512 Cedar et and Number or Rural Route Number, City or Town State, Zip Code)
T Garden Road, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Final Journey Crem. 9/11/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Ph\_sician/ COLORECEAL METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 Tyes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes 2 XNo Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 L 3 L Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MEDICA SEPTEMBER 09,2010 pellous DOCTOR BALTIMORE, MED reon who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 401 N. BROADWAY RANGACHARI JOHNS HOPKINS HUSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28521 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER Day, 2010ar Physician/ 9:35 Рм SHELLY LYNN PRACKO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE JOSEPH RITCHIE HOSPICE 5. Social Security Number 7, Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. M. Magnetts Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Country) MARCH DAY 9° 1958 MD Director 214-68-6372 52 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗓 No NOTTINGHAM MD BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 USA 5848 BELAIR RD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give altimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify. Specify "natural". 3 ☐ Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ PATRICIA GARGAN WILLIAM HECTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1238 S. CHARLES ST BALTIMORE, MD 21230 JASON PRACKO-SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 9/8/10 GLEN BURNIE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC . Signature of Funeral Service Licensee 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1 Enter the dis. 15 for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock. In the shock of dying, such as cardiac or respiratory arrest shock. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. signed by the attending physician and deed betached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 2 No 1 ☐ res ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manna of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending To the Hospital or Attendi within 24 hours after death To the Funeral Director; A Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

B<sub>E</sub>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09-08-2010 0247 A M Jacqueline Jean Reichenbach Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 12 - 30 - 1933 1 □ M 2 😾 F 76 191-26-2258 PA Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Bel Air 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 510 Old Stone Place 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give \$ 1 Yes 2 No Specify. White Specify: "natural", Completed 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Jenkins Marian Swoyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Old Stone Place Bel Air, MD 21014 Joseph Reichenbach (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 09-13-2010 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, MD Baltin 21. Signatur of Funeral Service Licentee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BleAir, MD 21014 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Advanced Metastatic Luna Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner arrithmia Cardino Securitielly list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): PE Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Possible acule NSTEMI Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kedney 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Hypercholesterolemy 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy left plural offusion Sacral 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation

Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier DOO68014 9/81/0 and address of person who completed cause of death (Item 23a) (Type, Print) apper Chisapeare Dr. Bel Arr, MD-21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8<sup>Day</sup> Physician/ Sept. 6:30 P M Raw1s 2010 Lovie Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenwald Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, ) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 212-03-2643 1 M 2 X F <sup>Ye</sup>1916 North Carolina 93 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Tes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 A Southerly Road 21286 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. White, etc. 1 X Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ James Dennis Rawls Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6620 Vista Heights Road; Bridgewater, VA 22812 Mary Hall 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/10/2010 Towson, Maryland 21, Signature of Funeral Service Li 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Pregnant at time of death signed by the a be detached f g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 autopsy death? 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred work Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) eleted dause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mo

Box 68760

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28524 State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 CLAUDE CARLIN RUTHERFORD SEPTEMBER 6. 6:50 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day 1 **X** M 2 □ F Months Days Hours Min. 1930 Maryland 217-26-7838 Director 80 Usual Residence of Decedent 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21154 **USA** 1302 Ouaker Church Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 

Yes 2 □ No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service 12 Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bessie Mae Cook John Hiram Rutherford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Christian Townsley / Nephew 30 Cedar Valley Road, New Park, PA 17352 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Hilltop Service Corp. 9-10-10 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice McComas Funeral Home, P.A. Dortwasce 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Goathall will Interval Between Onset and Death Immediate Cause (Final ASCVD complicated bu Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) To the Hospital or Attending Physician: The law requires that the death in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? certificate | 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ☐ Natural ☐ Accident 5 Pending injury 1 ☐ Yes 2 ☑ No -2010 Fall from standing 0400 AM Investigation □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined facilitu Bathroom in nursing 1302 Quacker Church Rd Street, MD Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nume Practices: The resulting seal occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nume Practices: The resulting seal occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nume Practices: The resulting seal occurred at the time, date and place and out to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifier 29c. License number D0070887 09/06/10 4+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kunai Chaildhru 500 Upper Chisapeake Drive Bel Air, MD 21014 Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 28525 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 11:05a James Ragin Sep 3, 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Towson Gilchrist Center for Hospice Care 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🖳 M 2 🗆 F Days Hours (Month, Day, Year) Director 249-44-5573 Apr 13, 1929 Carolina Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item———any injury or other trainmetin— 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1610 North Appleton Street 21217 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify Black Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse **Machine Operator** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Miller Louis Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1610 North Appleton Street Baltimore, Maryland 21217 Gardine Ragin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/09/10 Baltimore, Md. Oaklawn Cemetery 21. Sign of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutow Place Baltimere, Md 213 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician creatic pah disease or condition Medical resulting in death) ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 1 Live Birth 2 Li retail 4 Pregnant at time of death in the past 12 months? Month Year Day Yes 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Sacra decitato obstruction. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autonsy 2 🗌 No 1 Tes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 👿 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Deal Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

Pate

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

DHMH 17 Rev 7/2009

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Suite 4105 Bultimore, MD 21204,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28526 For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) SEPTEMBER <sup>Y</sup>2°0 10 6 4:00a<sup>M</sup> Physician/ ROMANS LILY MAE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE RIVER MIDDLE CHESAPEAKE HEALTH ASST 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex Hours Min MARYLAND 02 MOO 27 1 9 6 Davs Months **Funeral** 1 M 2 J 94 212 03 2291 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location shov 10b. County 10a. State filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 🗌 Yes 2 💢 No MIDDLE RIVER 28a-f BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number ō USA Completed by Funeral 21220 23a 9 BARBIE COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 12. Was Decedent Ever in U.S. Black, White, etc. 11. Marital Status Armed Forces 1 Never Married 2 Married 2 🔀 No WHITE 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 If Yes, Give 3 XWidowed 4 Divorced Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical College (1-4 or 5+) DEPARTMENT STORE Elementary/Seconday (0-12) and Mental Hygiene. SALES 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) KANTLER LILLY MAY of Health and Mental of Health and Mental fitem 27 is marked BARTON မ HARRY DEAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)DAUGHTER BARBIE COURT MIDDLE RIVER, MD 21220 TELLJOHANN HARRIETT A. 20c. Location - City or Town, State or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FULLERTON, MD ST. JOSEPH CHURCH CEM 9/9/10 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Service Licensee 21. Signature of Fur 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death seek Immediate Cause (Final dre hon Physician/ disease or condition Due to (or as a consequence of) resulting in death) Medical weeky Examiner Anorakia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine men ha attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 5 Other (specify) as been signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ⊡ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy HTH performed' Jas 2 🗌 No Yes 2 1 1 Yes Insullicem page After this certificate I renal 26. Place of Death (Check only one) 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certificate: To 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 27. Manner of Death injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide determined 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 918/10

State Registrar

DHMH 17 Rev 7/2009

Wend

1Clocs2 trar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

Kenwood

31295

Are

Balamore

2/206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year VO (O Settember 14:52 Physician/ BEAULAH ROULHAC Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner N/A BALTIMORE HOSPITAL - 1CU HARBOR If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1940 South Carolina Months Days Hours 1 □ M 2 🗓 F 70 Yrs. 579-54-3110 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f sho must be notified at Director 1 ¥ Yes 2 □ No Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21225 USA 746 Deacon Hill Court . Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after death Black, White, etc 1 Never Married 2 Married ö δ Black 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: If Yes, Give 3 Divorced Completed Year or Dates. 16b. Kind of Business Industry the Me fical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Tax Preparation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice Chestnut မ Dwyer Galloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 4729 Elison Avenue Baltimore, Maryland 21206 Health tem 27 Rosalyn B. Broom, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory Inc. 09/07/10 4 Donation 5 Other (Specify) Cremations Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licenses Thomas Gregor any in 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition ADENOCARCINOMA METASTATIC Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Year Month Day 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital: 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 XNo Certificate: To 1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September, 05, 2010 000 RES RESIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAITIMORE, MD. HANOVER STREET. UALENZUELA 3001 PERCY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Sept. Physician/ 2010 Patricia Η. Robertson Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Genesis Cromwell Center Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours May 7. Day 1931 1 M 2 X F 79 219-28-8181 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State aţ Examiner must be notified Maryland N/A Baltimore 這 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 23a 21214 United States 3047 Fleetwood Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. Hygiene. other than "natural", or i 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Government-Corp Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any Injury or other twarmarts. of Engineers Finance Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Sherrick George Horace\_ Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brian W. Robertson, Son 3047 Fleetwood Avenue, Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State Metro Crematory, Inc. 9/9/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Cremation Society of Maryland, Inc. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or Examiner MYOCAR DIAL TNIFARCTION Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician by Physician/Medical Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed PAROXYSMAL ATRIAL FIBRILLATION 24a. Was an autopsy performed? TO THRIVE 2 1 25. Was case referred to medica Be

this certificate To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I **Division of Vital** 

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Certificate:

Medical

Accident

Suicide

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Tyes 26. Place of Death (Check only one, examiner? 1 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) injury 1 🔀 Natural 5 Pending

1 ☐ Yes 2 ☐ No

28528

3. Time of Death

1:25p

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between Onset and Death

Day

1 X Yes 2 No

Mary land

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DEAD006967

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 308 KAUDINDI NEUTANIST BALTIMORE

State Registrar

Investigation 6 Could not be

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7:30 AM M September 1, 2010 Stephanie Leigh Reynolds /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil 539 Post Road Rising Sun | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Oct 29) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1965 Maryland 44 216-74-7774 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Industrial in the first of items 23a or 28a-1 show Important; If item 7 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, It a Redict Examinet must be a cultical at 1 ☐ Yes 2 ☑ No Director Rising Sun Cecil MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21911 USA 539 Post Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Wayne Reynolds Maryland Neff 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland Neff/mother 539 Post Road Rising Sun, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition as disease or condition as death)

a. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown à signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and titl of certifier 20023322 9.3.2010 1acader 8mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S SACHDEU MD 126 A, E fuch St 126 A, E trigh EREM MD 21921 31. Date filed (Month, Day, Year) State 1 0 2010 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 7,2010 **Physician** 5:20P Helen J. Stark /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto. Glen Arm Glen Meadows If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. June 30. 1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** 1□ M 2√ F Months Maryland 87 218-14-9797 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Im Middle Event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Glen Arm Director Md. Balto. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21057 USA 11630 Glen Arm Rd. Apt. 307 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isabelle K. Doyle George W. Feehley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2925 Ayres Chapel Road White Hall, Md. 21161 Helen Clisham DTR. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 0aklawn 9-10-2010 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li Schimunek Funeral Home d Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months disease or condition resulting in death) 20161614 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Bowel 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RB 79544 2010

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of perso

6565

4105

Towson, 20 21204

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SIE

SI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 28531 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12 Noon M Physician/ Mary Stefanek eptember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. Perry Hall 9601 Haven Farm Rd. 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Days Hours 84 Director 217-20-3565 12. 1926 Maryland Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Perry Hall 1 ☐ Yes 2 🙀 No Balto. Md. 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? "C" 21128 Funeral USA 9601 Haven Farm Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 14 Race - American Indian 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances Dora Langley William Murray Amoss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 729 Hickory Limb Cir. BelAir, Md. DTR. Donna M. Trageser 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-9-2010 Balto. Md. Gardens of Faith Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 21236 Belair Road 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SQUAMOUL CELL CARRINGMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 11 MONTHS IN WE CANCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of attending physician and for use as the burial-transit 2 MONTHS requires that the death certificate be executed USSPINATORY that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MALNUMITION 2 No 3 Probably 4 Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) the Hospital or Attending Physician: Be examiner? Hospital Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) D2813 nd address of person who completed cause of death (Item 23a) (Type, Print) ATIMORA MA #401 31. Date filed (Month, Day, Year) 32. Registrarts Signat State

DHMH 17 Rev 7/2009

Registrar

10-06558 Nathaniel Santiago Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 28532

Certificate of Death

		Registrar		Ce	ertificate d	n Deal	U)			R	eg. No.			
Physici Vledical Exami	an/	Decedent's Name (First, Midd     NATHANIEL AUG		IAGO, SI	R.					Date of Dea Month August 3'	Day	Year	-	3. Time of Death 0127 hrs
		4a. Facility Name (if not instituti Johns Hopkins Hospi		umber)		4b. City, Baltir	Town, or L more	ocation of	f Death		4c. 0	County of I	Death	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Und	der 1 Year	If Under	Min.			F	oreian	place (State or
Director		220-92-7603 Usual Residence of Decedent	1XM 2 F		31 Y	rs.				AUG. 1	16, 1	979	Cour	ntry) MD
, any		10a. State 10b. County		10c. City	, Town or Loc	ation								0d. Inside City Limits
Maryland 28a-f show 1 at once.	ţ	MD 10e. Street and Number		BAI	LTIMORE		0-4-			1.	0. 011-			1 X Yes 2 No
hours after death with the Maryland 'natural'', or items 23a or 28a-f sho Examiner must be notified at once	Director	4112 HARRIS A	ישר			10f, Zip	1206				USA	n of What	Count	y?
th with	Funeral	11. Marital Status  1 Never Married 2 X M	12. Was Dec	cedent Ever in U		as Deced				ify Yes or No		4. Race - A		n Indian, Black,
fter dea			1 Yes	2 X No	1		X No				S	pecify: V	VHI'	Œ
)36 thin 72 hours at the. than "natural	ed by	15. Decedent's Education (Spe			16a, Decede	nt's Usual		n (Give k			16b. Kin	nd of Busin	ness/Inc	lustry
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5-0( led wi Hygien other	ပ	17. Father's Name (First, Middle	, Last)		CAS	HTEK	18	3.Mother's	Name (F	irst, Middle, I				
2121 uld be fi Mental I marked	o Be	LUIS SANTIAGO  19a. Informant's Name/Relations			19h Maili	a Address	S (Stenat		I SAN	TANA al Route Nur	abas City	as Tourn	Chata =	En Cada)
MD 2 nd 2 shou alth and N m 27 is n		DANIELLE SANT				-	RRIS A			TIMORE			206	ip code)
re fr		20a. Method of Disposition  1 X Burial 2 Cremation			Place of Dispo crematory or o			etery,		ate		cation - Ci	ty or To	own, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service	,			LAWN		C C	9/08	/2010	BA	LTIM	DRE,	MD
Bal permi Depa Impo		Mes C	han	Je						EY CHA E., BA				L. HM. 21231
Physician /Medical		23 Part I. Enter the sease, or failure. List only one cause		sed the death										Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		ound of Che									-	Death
	ايا	Sequentially list conditions,	b		-6.								$\dashv$	
_	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C	consequence o										
executed an and al-transit		events resulting in death) Last	d	consequence o	от):									
_ <b>-</b> 8 .⊒.⊑	n/Medical	UNPENDED	AMENDED											
8760, tificate be ing physic as the bur	JW/W	IF FEMALE: 23b, Was decedent pregnant in the past 12 months?	ne 1 Live b		2   F	etal death	3	Ectopic	pregnancy	,		Date of del onth	livery Day	/ Year
Box 68 he death cert the attending	Physicia		4 Pregn	ant at time of de	anth -	ther (Spe	cify)							
Records, P.O. Box 6  The law requires that the death cer icate has been signed by the attendi page 2 should be detached for use.		Part II. Other significant condi			resulting in the	underlying	g cause giv	en in Part	t I.	23e. Did to	bacco use	e contribut	te to the	cause of death?
IS, P quires then signe an signe	ted by			<u> </u>					- 1					oly 4 Unknown
of Vital Records, g. Physician: The law requir when this certificate has been s neral director, page 2 should	Completed										sy m <u>ed</u> ?		r to con	osy findings available apletion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medica	<u> </u>				26.Place o	f Death (C	Check only	1 Yes	2 No	1 🗸	Yes	2 No
Vita hysicia this ce	o Be	examiner? 1  Yes 2 No	Hospital: 1	npatient 2 🗸	ER/Outpatier	t 3 🗍 D	OA O	ther <sub>4</sub>	Nursing H	lome 5	Residence	e 6 🗌 (	Other:	
<b>~</b> = . ^ 2	io ::	27. Manner of Death  1 Natural 5 Pend	28a. Date (Month Aug 31,	of Injury , Day, Year) 2010	28b. Time of 0037 hrs	Injury 2	28c. Injury	at Work? s 2 ✔ N	leu	d. Describe l bject sho		occurred		
Division tal or Attendir rs after death. at Director: A	ertification:	2 Accident Inve	stigation	e of Injury - At h	ome, farm, stre	et, factory			- 7			Number o	r Rural	Route Number, City
Divis spital or At nours after d neral Direct	Cert			Local Stre	et				412	or Town, S 22 Harris A	tate) venue, B	altimore,	MD	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(Check only	hysician: To the bes miner:On the basis	of examination a										ause(s)
To To	Me	29b. Signature and title of certific		ia(eq.		290	c. License r	number	•		29d, Dat	te signed	(Month	, Day, Year)
		my mi	(m)				O.C.M	.E.			Augus	st 31, 20	)10	
		<ol> <li>Name and address of person Ling Li, MD Assista</li> </ol>	who completed caus nt Medical Exar		n 23a) Penn Stre	et, Baltii	more, M	D 2120	)1					
	-100	31. Date filed (Month, Day, Year)		gistrar's Signatu										
Regist	Iteli	SEP 102	010 Den	me B	par	Tal .								

**ORIGINAL** 

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	_	For State of Maryl				Mental Hy	giene 20	10 2853
		Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	eatn	2. Date of De	Reg. No.	3. Time of Deat
Physiciar Medica		Caryle Adele Sybert				Month	, Day	Year 2010 6:00 f
Examine		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Baltim			4c. County	of Death
Funeral Director		216 28 1675 1 M 2 X F	78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 04/09/	th y, Year) 1932	9. Birthplace (State or Fore Country) Maryland
at at	۱	Usual Residence of Decedent	. City, Town or Loc	cation				10d. Inside City Lin
28a-f s	rect	Maryland Baltimore	Nottingh	am				1 ☐ Yes 2 🔯
ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 4102 Taylor Avenue		10f. Zip Code	1236		10g. Citizen of V	What Country?
ral", or ite	ρ	I1. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	lf .	Vas Decedent of His f Yes, specify Cubar	, Mexican, Puerto			e - American Indian, ck, White, etc. White
tal Hygiene. sd other than "natural", event, the Medical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	(Give H	lent's Usual Occupa kind of work done do O NOT use retired)		king		or no. Homo
t te	d)	17. Father's Name (First, Middle, Last)	HOM	emaker	18 Mother's Nam	ne (First Middle	Maiden Surname	Own Home
and Mental is marked o raumatic eve	2	John W. Talbott Sr.				Marjor	ie Lee	Edwards
of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Ralph J. Sybert (husband	d) 4102	g Address (Street a Taylor A	nd Number or Rui Venue N	al Route Number ottingh	r, City or Town, S am, Md 2	State, Zip Code) 21236
out of H		1 Rurial 2 XCremation 3 Removal from State		sition (Name of natory or other place rematory		Date /2010		City or Town, State
Department of Department of Important: If it any injury or once.	Ì	21. Signature of a rail Service Licensee	22		s of FacilityBru	zdzinsk	i Funera	al Home PA
bysician/ Medical Examiner  the private and th	edical Examiner	Immedian Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cardioo  Due to (or as a condition of the cause)  Due to (or as a condition of the cause)  Due to (or as a condition of the cause)  Due to (or as a condition of the cause)	sequence of): sequence of):  Av+6	snock v Myoc evy Dis	ardia	Linf	ircho	Onset and Death
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ar deathscriptorare	d by Pt	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.			ribute to the cause of death?
ate has been page 2 should	Somplete					24a. Was auto perfo	an 24b. Vosy primed?	Were autopsy findings availe prior to completion of cause death?
sertific ector,	&   B	25. Was case referred to medical examiner?		Othe	ce of Death (Chec			
After this uneral dir	ate: To	1  Yes 2  No 1  Inpatient 2  7. Manner of Death 1  Natural 5  Pending  (Month, Day, Yea	2 ER/Outpatien 28b. Time of injury	at 3 L DOA 28c. Injury work?	4 ∐ Nursing H at		dence 6 Other	
	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - Abuilding, etc. (Spot			Yes 2 □ No	28f. Location (S City or Tox		er or Rural Route Number,
within 24 hours after to the Funeral Director of the Funeral Director of the filled in	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my ki	nation and/or invest	igation, in my opinio	n, death occurred a	at the time, date a	and place, and due	e to the cause(s) and manner
withir comp		29b. Signature and title of certifier		29c. License	number		29d. Date signed	d (Month, Day, Year)
1		30. Name and address of person who completed cause of death (  THET CYEBI-FOSTER  31. Date filed (Month, Day, Year)  32. Registrar's Si	(Item 23a) (Type P	AT 24	38946		Septem	ber 8, 2016
4		JULIET GYEBI-FOSTER	UNION	MEMORI	AL HOSE	PITAL,	BALTIN	NORE, MD 21
State Registra	e r	81. Date filed (Month, Day, Year) 32. Registrar's Si	gnature Sark			ŕ		-

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perINF, G907, 9/2972010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 4:10pmM Laura Jean Smith 00 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A 4b. City, Town, or Location of Death **Examiner** Baltimore Union Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Sept. 19 9. Birthplace (State or Foreign 219ial82uri7853er **Funeral** Country) Maryland Months Days Hours Min Director 47 1962 Sept. Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21211 3528 Hickory Avenue United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Race Track Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joan Gardner Whitey Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy D. Welk, Brother 1217 West Cross Street, Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 ဳ Cremation 3 🗆 Removal from State cemetery, crematory or other place, 9/8/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Adenocarcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** days Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29331 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brandon 201 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. In Sure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAGGIE AMonth SMITH Physician/ MANDONIA 2010 . 05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Frederic Andover rederick 7. Age (In yrs Jast birthday) 95 Yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth Funeral 1 M 2 XF Months Days Hours Min 09/25/1914 Director 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick 1 Yes 2 No 10e, Street and Numbe 10g. Citizen of What Country? Funeral 21702 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 100 Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: If Yes, Give Year or Dates Blac 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) omestic loth Be s Name (First, Middle Last 18. Mother's Name (First, Middle, Maiden Surname) ည eman tnnie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yorkman Andover Lane, trederick, broth Baltimore, Place of Disposition (Name of cemetery, prematory of other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -1-10 21. Signature of Funeral Service Licensee 22. Mand Aldress Fracili Greene Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner CARDIOVASCULAR DISEASE YPERTENSI SEVERAL Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of YEARS Cause (Disease or iinjury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Day Year signed by the at d be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð ALZHEIMER'S Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No HEMATO MAS SUBDUR After this certificate funeral director, pag 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 🗷 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours a
To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) D0018362 Komal 25-201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m.D. 3455 Wilkens Are Ste LIO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

For State Registrar 1. Decedent's Na Sall Physician/ Medical 4a. Facility Name Examiner Shady 5. Social Security 1398 **Funeral Director** 080-24 Usual Residence permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State by Funeral Director 913/10 C MD 10e. Street and N 12504 11. Marital Status 1 Never Ma Baltimore, Maryland 21215-0036 Be Completed 3 X Widowed 50-11Y (S Elementary/Se 12 17. Father's Name Schreiber, ၉ Sol Le 19a. Informant's Naomi 20a, Method of Di 1 🗌 Burial 4 Donatio 21. Sign at tre of F 23a. Part 1. Ente shock, or he Immediate Cause disease or condi-resulting in death Physician/ Medical **Examiner** Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated ever Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran resulting in death Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decede in the past 12 1 Yes 2 9 Unknow Part II. Other sign 25. Was case reference examiner? 27. Manner of Dea 1 Natural
2 Accident
3 Suicide 4 Homicide Medical 29a. Certifier (Check only one) 29b. Signature an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jo.e

(First, Middle, Last)		Certificate or	f Death		Reg. Nø?	0 28536
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That institution, give street and number)			, or Location of Death		4c. County	
Grove Hospital Imber   6. Sex   7. A	ge (In yrs. last birth		ar If Under 24 Hrs.	8. Date of Birt	h	9. Birthplace (State or Foreign
-5789 1 □ M 2 💢 F	79	rs. Months Day	s Hours Min.	May 13	, Year) 1931	New York
Decedent 10b. County	10c. City, Town	or Logation				10d. Inside City Limits
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eat Park Circle #	101		20876			USA
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ed 2 Married 1 Yes 2		1 ☐ Yes 2 🔯		1 110411, 010.)	Specify:	k, White, etc. white
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me/Relationship ( <i>Type, Print</i> ) yan/daughter	19b. I 80	Mailing Address (Stre	et and Number or Rura Prchard Blv	Route Number	r, City or Town, S aithers	tate, Zip Code) burg,MD 20878
osition		Disposition (Name of		Date		City or Town, State
Cremation 3 Removal from Stat	te cemetery	, crematory or other p	place)	pate [	200, Location -	City of Town, State
5页Other (Specify) in stat	е	22 Name and Add	intress of Facility			
onald Salade, Dir	ector	State Ana Baltimore	tress of Facility TOMY Board MD 2120	655 W. l	Baltimo	ore Street
ne disease, or complications that cause t failure. List only one cause on each li		•	·		est,	Approximate
inal  - Gast	rointes-	tinal BI	end			Interval Between Onset and Death
_ a _ U/U-12 1		11/100	000			
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Center Drive, Rockville, Md. 20850

State Registrar Medical

9901

32.

egistrar's Signatur

MD

31. Date filed (Month, Day, Year)
SEP 10 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 tem 20b per ff g907 9-10-10 yt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SeDtembe Day : 05 PM 201 Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death **Examiner** 4c. County of Death Temo tospita HMORE 8. Date of Birth (Month Day, 7. Age (In yrs. last birthday) If Under 24 Hrs. Numbe If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Hours Country) Yrs. Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 6 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural" 3 XWidowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working inte. DO NOT use yetired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ ALon Onor 19a. Informant's Name/Relationship (Type, Print)... Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trae HaltIMORE 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer / ervice Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 \sum No 3 Ectopic pregnancy Month Dav Year Pregnant at time of death 5 Other (specify) 1 X Yes 2 D 9 D Unknown page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No this certificate 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Math 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the d 29a. Certifier (Check 29b. Signature and title of certifier 0 s of person who completed cause of death (Item 23a) (Type, Print) MH I Himore 31. Date filed (Month Registrar's Sign State 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 10:00 A M Stokes 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Beyriew Medical Center Battimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗐 F Days Hours 66 Director Sept 219 38 2356 Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 N. Kenwood Ave. 21205 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces' ģ 1 Never Married 2 Married ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event; the Medical Exa If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Hardee's 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harold Richardson Alice Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvina Richardson (grandaughter) 725 N. Kenwood Ave. Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Tremation 3 Removal from State Green Mount Crem. Sept.11,2010 4 ☐ Donation 5 ☐ Other (Specify) Balto, Md. 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home
1412 E. Preston St. Balto.Md. na ure of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ organ system MultiPla disease or condition Medical resulting in death) Examiner Preumonia Sequentially list our ditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 e attending pl d for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🛂 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Tatthew

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Konerman M.D

102010

29c. License number RES-000

1200 South Conking St. Apr. 350 Baltmore, MD

September, 7,

28539

			- FOI	cate of Death Reg. No.	
	Physici /Medio Examir	cal	1 Decedent's Name (First, Middle, Last)	2. Date of Death  Splenher 3. 2010 12:52 f  City, Town, or Location of Death  4c. County of Death	M
	LAAIIIII	ici		altimore City	
=	Funeral Director			Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day Year)   9. Birthplace (State or Fore Country)   9. Birthplace (State or Fore Country)   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940   1940	ign .a
	and w	ō	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location           MD         Baltimore         Middle Ri	, = v	
	with the Na or 28a- be notified	Director	10e. Street and Number 109. F. Kingston, Pk. Land	0f. Zip-Code 10g. Citizen of What Country? 21220 United States	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	198 E Kingston Pk Lane  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Decedent of Hispanic Origin? (Specify Yes or Nos, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White	
21215-0036	vithin 72 houne. The "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's (Give kind life. DO N If a complete (1-4 or 5+)  College (1-4 or 5+)  Finis	's Usual Occupation of work done during most of working NOT use retired)  Sher  16b. Kind of Business/Industry  Dry Wall	
land 2	should be filed within and Mental Hygiene. s marked other than ' umatic event, the Mer	To Be Co	Filmond Trimble	18. Mother's Name (First, Middle, Maiden Surname) Sarah Elizabeth Snyder	
Maryland	: 1 and 2 should be Health and Mental tem 27 is marked of other traumatic eve		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Ac	ddress (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Grovethorn Rd. Middle River, MD 21220	
Baltimore,	permit. Pages 1 am Department of Heal Important: If item 2 any injury or other		-	e Crematory 2010 Beltsville, Marylan	d
Balt	permit. Departr Imports any inj			Grematuron family Funeral Alternatives 717 Green Pastures Drive Towson Maryland 21286	
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequent) of):	Interval Between Onset and Death	
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68760,	tificate be executed g physician and as the burial-transit	Medical E			
O. Box 6	death cer e attendin ed for use	Physician/Me	IF FCIVIALE.	topic pregnancy 23d. Date of delivery her (specify) Month Day Year	
J.	Se du	by	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	
I Records,	ne law has b ge 2 s	Completed	· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy findings availated prior to completion of cause death?  1  Yes 2 No 1 Yes 2 No	ble of
Vital	Physician; The this certificate and director, pa	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)  Other: 4   Number Home   5   Residence   6   Other (Secolar)	
ō	S O	ition: To		B DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)  28c. Injury at Work?  M 1 Yes 2 No	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, fibuilding, etc. (Specify)	factory, office  28f. Location (Street and Number or Rural Route Number, Cify or Town, State)	
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical (		curred at the time, date and place, and due to the cause(s) and manner as stated.  igation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
	To the withing To the comp	Me		29c. Licanse number 29d. Date signed (Month, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print	1775-000 Sepember 3, 200	
`			Christopher J. Abularraga MD	600 North Wolfe St, Baltimore, MD, 212	287
	Sta Regista		31. Date filed (Manth, Day, Year) SEP 10 2010 Server 9. Signature		

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		State of Maryl		artment of H tificate of D			20	110 2851.0
		1. Decedent's Name (First, Middle, Last)		incate of B	Catif	2. Date of Dea		3. Time of Death
Physicia Medi		Ernestine E. Taylor				Septemb	er <sup>□ay</sup> , 2	20 <sup>°</sup> 10 2:40 A м
Exami		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County	
Funeral		Gilchrist Center  5. Social Security Number   6. Sex   7. Age (In y.)	rs. last birthday)	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	Balti	9. Birthplace (State or Foreign
Director		219-28-9699 1 D M 2 M F 80	Yrs.	Months Days	Hours Min.	127097		Catonsville, MD
ld now		Usual Residence of Decedent  10a. State 10b. County 10c.	. City, Town or Loc	eation				10d. Inside City Limits
arylan a-f sh ified a	Director		uthervil1					1 🗆 Yes 2 😿 No
the M or 28 e noti	Ë	Maryland Baltimore Lu 10e. Street and Number	achier v i i	10f. Zip Code			10g. Citizen of	What Country?
with is 23a nust b	Funeral	5 Pickett Garth		21093			U.S.A	۹.
death ritem iner n		11. Marital Status 12. Was Decedent Ever in Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - American Indian, ack, White, etc.
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2-005 2 hours aft "natural", dical Exa	olete	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupa and of work done de		na l	16b. Kind of B	Business Industry
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d be filed Aental Hy Irked oth	은	Ernest Hottenbacher			Louise V	leigand		,
should and h is me		19a. Informant's Name/Relationship (Type, Print)		g Address (Street a				
ife, INTALYIGHTU ZIZIO-UOOO 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Norman J. Taylor/ Husband  20a. Method of Disposition	b. Place of Dispos	ckett Gar	-			
Daltillord permit. Page 1 a Department of H Important: If ite any injury or ott		1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State	cemetery, crem	alley Mem	)	3/2010	Timoni	- City or Town, State
Dallinor  Dermit. Page 1  Department of  mportant: If it  any injury or c		21. Signature of Funeral Service Licensee		. Name and Address				uni, 110
Deparmit any in once.		Myn Seliski	R	uck Towso	n Funera	vson, MC I Home,	Inc. 10	050 York Road
	П	23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	leath. Do not ente	r the mode of dying	, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		G						
h certi	Physician/M	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pre	egnancy Fetal death 3	Ectopic pregnancy	,			ate of delivery
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law requires nas been sig	Completed					24a. Was a	sv	Were autopsy findings available prior to completion of cause of
The I: The I cate h						perfor	med?	death? 1  Yes 2 No
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g Phy g Phy er this ieral d	te: To	27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury	at Nursing Ho	me_5 ∐ Residence 128d. Describe ho		
eath. or: Aff	fical	1	r) injury	M 1 🗆 Y	∕es 2 □ No			
or Att after d Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - A building, etc. (Spe		et, factory, office		28f. Location (Si City or Town		per or Rural Route Number,
spital nours neral I		29a. Certifier 1 Certifying Physician: To the best of my kn	nowledge, death o	ccured at the time,	date and place, and	d due to the cau	ise(s) and mann	ner as stated.
he Ho iin 24 I he Fu	Medical	(Check 2 ☐ <b>Medical Examiner:</b> On the basis of examination only one) 3 <b>Certifying Nurse Practioner:</b> To the best of						
Vith Vith Con Con		29b. Signature and title of certifier		29c. License	number	2	29d. Date signe	ed (Month, Day, Year)
		30. Name and address of person who completed cause of death (I			< 2 2 S	8	ما	109/10
101		UFOIN, Charks SF SL	тет 23а) (Type, Pr	TOWS	n. 115	212	enno 204	NA, seno
Sta		31. Date filed (Month, Day, Year) SEP 10 2010 SEP 10 2010	gnature	,	. , , , , , , , , , , , , , , , , , , ,	,		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 Physician/ 21:23 M nompson Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** oward Count Genera olumbia Howard Hospita Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 👿 F Hours 70 (Month, Day, Year) 9 Co Waryland Director 219-38-7412 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If itein 27 is marked other than "natural", or items 23a or 28a-1 sho. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director X 1 Yes 2 No **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 21223 2532 McHenry Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 Yes : 2 No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Biddle Street Caterers Elementary/Seconday (0-12) Food Service Employee 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Rosalie Alston 2 Charles L. Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 534 So. Catherine Street Baltimore, Maryland 21223 Traci Herrington Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal\_from State Brooklyn Park, Md. 09/07/10 Cedar Hill Cemetery & Mauscleum 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, of heart failure. List only one cause on each line Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed labe that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 . death? After this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Director: Suicide Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 66866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedar lane olumbia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	arylan	d / Depa <i>Cer</i> i	rtment of tificate of	Health a <i>Death</i>	and M	lental Hy	giene Reg. No	2010	28542
	ysicia Medic		1. Decedent's Name (First, Middle, Last) Margaret Vir		Tyle	r				2. Date of De		2010 Year	3. Time of Death 7:35P M
	xamin		4a. Facility Name (if not institution, give s Gilchrist Center	treet and number)			4b. City, Town, o		f Death			. County of Deat Baltim	ore
	neral ector		5. Social Security Number 6. Sex 213-01-4042	7. Age	95	st birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da June 9,	th y, Year) 1915	9. Birl	inplace (State or Foreign untry) Limore, MD
ryland	led at	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         Harfo	rd	,	Town or Loc Bel Ai							10d. Inside City Limits 1 ☐ Yes 2 X No
ith the Ma	st be notif	Funeral Director	10e. Street and Number 20 Huntington Pl				10f. Zip Code	014			-	itizen of What Co	
Yiand 21215-0036 Id be filed within 72 hours after death with the Maryland Mental Hygiene.	or other trian fractions, or items 25s or 25st snow event, the Medical Examiner must be notified at	à	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🎇 If Yes, Give Year or Dates.		If	/as Decedent of National American Amer	an, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White	
rithin 72 hours after fiene.	the Medic	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		+)	(Give k	ent's Usual Occu ind of work done NOT use retired istrative	during most )			1	Kind of Business Bendix	Industry
baltimore, Maryland 21.2 permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important. If them 27 is marked other the	tic event,	To Be	17. Father's Name (First, Middle, Last)  John Smith							(First, Middle, a Sanford		Surname)	
, Mary nd 2 should saith and N	er trauma		19a. Informant's Name/Relationship (Type Anne Tyler/ Daug				g Address (Street un tingt (	on Pla	ace, E	al Air,		r Town, State, Zip 101 4	Code)
Saltimore,  bermit. Page 1 and Department of Hea	ury or oth		20a. Method of Disposition 1 □ Burial 2 <b>X</b> Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)				ition (Name of atory or other pla ral Chal	Sel S	ept. <sup>0</sup> 2010	9 <b>,</b>		ocation - City or est Hil	Town, State 1, Maryland
balt permit. Depart	any inj once.		21 Signature of Funeral Service License	LU		<b>15</b> 7 88	Name and Addr ans fune 00 Harfo	eral C	hapel	. & Crema	tion MD 21	Serviœ 1234	s
Physic			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition	e cause on each line			the mode of dyli	ng, such as c	cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
Exan	dical niner	<u>.</u>	resulting in death)  Sequentially list conditions,		nate	mus	is						days
ecuted	transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a		,						j.	V- •-
rate be executed physician and	s the burial-transit	edical	resulting in deathy East.	d									
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending in	hed for use as	ŽΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗀 Fetal	death 3 🔲	Ectopic pregnan Other (specify)	су				23d. Date of del Month	ivery Day Year
es that the signed by	be detac	d by Ph	Part II. Other significant conditions con	tributing to death bu									the cause of death?
The law requires ate has been sic	oage 2 should	Completed by						7		24a. Was	an	24b. Were aut prior to death?	opsy findings available completion of cause of
VILCII   /sician:   s certifica	rector,	Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	ospital:			_ Oth	lace of Deatl		only one)			lias Oraș
nding Phy ath. :: After this	e funeral d	icate: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day,	y 2	ER/Outpatient 28b. Time of injury	28c. Injui wor	y at	2	ne 5 ∐ Resid 8d. Describe h		Other (Speci y occurred	b) IIIII
DIVISION tal or Attendir s after death.	ed in by th	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.		ne, farm, stree	et, factory, office		2	8f. Location (S City or Tow			al Route Number,
he Hospit in 24 hour	pleted fill	Medical	29a. Certifier (Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of ex	amination	and/or investig	gation, in my opini	on, death occ	curred at t	the time, date a	nd place	, and due to the o	ause(s) and manner stated.
To t With	COIT		29b. Signature and title of certifier				29c. Licens	-	2 -		29d. Dat	te signed (Month	, Day, Year)
F	$\setminus  $		30. Name and address of person who co				int)	106?				110	
Re	Stat gistra	Ç.	31. Date filed (Month, Day, Year) SEP 10 201	32. Registrar	الالح s Signatu		Balti	more,	MI	) 21	20-1	6	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28543 State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ihomsen Saptember Frances 7:52 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours June 16, 1952 Country) West Virginia 1 M 2 🔯 F 217-54-0893 58 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitied at once. 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎦 No Dundalk <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Unites States 21222 7818 Deboy Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Years 2 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martha Ahern George Evans Husband 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert L. Thomsen, Sr. Dundalk, Maryland 7818 Deboy Ave. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Gardens of Faith Cem. 8/11/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland when 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulnenary disease or condition resulting in death) how Medical hours Examiner days Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year the g Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coloncancer sip colector 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No XYes 2 □ No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1° 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. atthe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1700 South Conking St. Apt 350 Beltimere, MD 21324 Konerhan, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

10-06651 Roderick Torian Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #19ate of Maryland / Department of Health and Mental Hygiene 2010 28544

LUME

		1- For State Registrar		Ce	rtificate o	f Death			Re	g. No.	
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)		4a. Facility Name (if not institution 201 N. Washington S	_	mber)		4b. City, Town, o Baltimore	r Location o	of Death		4c. County of D	eath
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	_		8. Date of Birt		Birthplace (State or reign
Director		243-68-8393	1 M 2 F	66	Yrs	Months Da	ys Hours	Min.	Aug.3	30,1944	Country) NC
any		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Locat	ion					10d. Inside City Limits
<u>*</u>		Md n/a	1		Bal	timore					1 X Yes 2 No
4aryland 28a-f show Latonce.	cto	10e. Street and Number				10f. Zip Code			10	g. Citizen of What 0	Country?
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Baltimo permit. Page Department of Important: injury or otl		4 Donation 5 Other S	Decify:	Gre	22. N	lame and Addres	s of Facility			0 Balto	
Ba Pern Dep Dep	(	al N	D		Ç	ALYIN I	B. SC	CRUGO	GSTFUN	ERAL HO BALTIMOR	ME E,Md 21213
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	used the death	. Do not enter th	ne mode of dying	, such as ca	ardiac or re	espiratory arres	st, shock, or heart	Approximate Interval
/Medical £xaminer		Immediate Cause (Final disease		osclero	tic Car	diovascı	ılar I	)isea	se		Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a					• • •			
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A . B . E	Examiner	events resulting in death) Last	Due to (or as a	consequence o	f):						
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- 0 '5'-6	Physician/Medical	IF FEMALE:						6,00		CHEET	
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Box 68 e death certi the attending ed for use as	<u> </u>		4 Pregna	ant at time of de	ath	ner (Specify)					
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, P.O. Box 687 res that the death certific signed by the attending to be detached for use as the	٥	Part II. Other significant condit	ions contributing to	death but not re	esuiting in the u	nderlying cause	given in Par	τι.			to the cause of death?  robably 4 Unknown
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COFC law re has be	휠								autopsy perform	y prior t	o completion of cause of
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f Vi Physi er this	္	1 Yes 2 No 27. Manner of Death	28a. Date o		ER/Outpatient 28b, Time of Ir		ry at Work?			esidence 6 🗸 Ot	her: Scene
n of iding Pl h. : After e funera	<u>ë</u>	1 X Natural 5 Pend	(Month,	Day,Year)	200. Time or ii		Yes 2	i i	u. Describe no	w injury occurred	
IVISIOR or Attence after death Director:	g	2 Accident Inves	stigation 280 Place	of Injury - At ho	ome farm stree	t, factory, office b			of Location (St	reet and Number or	Rural Route Number, City
Division of Vital Records, spital or Attending Physician: The law requiriours after death.  neral Director: After this certificate has been sifilted in by the funeral director, page 2 should be	Certification:		d not be (Specify)	or inguity Turne	51110, 1d1111, 0t1 00	i, ractory, office i	zananig, etc		or Town, Sta		Nata Notic Hamber, Oity
Hospi 24 hou Funer cely fil		20a Certifier	nysician: To the best	of my knowled	ge, death occur	ed at the time, da	ate and place	e, and du	e to the cause	(s) and manner as s	tated.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certil within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		miner:On the basis o	f examination a							
5,25,8	Me	29b. Signature and title of certifie		a.vu.		29c. Licens	e number			29d. Date signed (!	Month, Day, Year)
		Vousante.	ne Youl	l		O.C.	M.E.			September 4, 2	2010
of arma	ŀ	30. Name and address of person	who completed cause	of death (Item	23a)						
Nho.	_	Margarita Korell MD.	Assistant Med			enn Street, B	altimore,	MD 21	201		
St Regist	ate	SEP 1 2010	Deneus 32. Reg	gistrar's Signatu	re Kal						
Regis	1EI	VEI AVAUIU	Janes J.	10 1 16 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Pill Mudhin						i

Please Type or Print in Black Indelible Inky Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 8 Vansan 12:10 am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Severna Park Heartlands Asst Living Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Days Months Hours 1 □ M 2 😾 F Yrs 98 Director 10. Maryland Aug 214-05-1180 Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples of the could be notified at 1 ☐Yes 2☐ No Directo Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 715 Benfield Road 21146 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: white Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) furniture store 0 bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic even Catherine Louise Rochlitz Henry Louis Haneke မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 715 Benfield Road Severna Park, MD 21146 Anna Haneke/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (\$pecify) State Anatomy Board 655 W. Baltimore Street 21. Signature of Superal Service esicen Wade Baltimore, MD 21201 23a. Part 1. Ent 3, the disease, or comic cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** rena /Medical Due to (or as a consequence of) Examiner 6-12 months chronic kidney disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burlar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1∐Yes 2 No the 9 Unknown 9 Unknown þ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe this certificate 2 🗆 No 1 □ Yes 2 **N**o 1 ☐ Yes or Attending Physician: after death. assisted 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Dother (Specify) Vina Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To hours after death.

Ineral Director: After this
iy filled in by the funeral d 27. Manner of Death 1 Watural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Hospital o 24 hours af e Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the 29c. License number 150725 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

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ame and address of person who

enniter

31. Date filed (Month, Day

d cause of death (Item 23a) (Type

en

32. Registrar'

8601

rars Hwy Millers v. Cle Mi 2/108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 6, 2010 2:54 A M **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore The Johns HOPKINS HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12/03/1946 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □XM 2 □ F 63 Troop, PA 173-38-2341 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninat must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 XNo Director Lackawanna Scott PA 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code U.S.A. 18447 182 Green Grove Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Contractor 12 Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvia Mazzatta Joseph Wasko ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 182 Green Grove Rd., Scott Twp., Pennsylvania, MaryAnn Wasko 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🌣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Archbald, PA Maple Hill Crematory 9/10/2010 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility 445 Sanderson Street, Troop, PA 18512 John F. Glinsky F.H. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician epsis disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner munosu Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of Records, P.O. Box 68760 Physician/Medical s been signed by the attending I should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 st autonsy performed? (es 2 No 1 ☐ Yes 2 ☐ No 1 □Yes Division of Vital the Hospital or Attending Physician; 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral direction Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation within 24 hours are: control to the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Seftember 6, 2010

Registrar
DHMH 17 Rev 1/2001

State

600 North Wolfest, Baltimore, MD. 21287

30. Name and didress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Raymond (xivens,

ed (Month, Day, Year)

			1 - State Registrar	State of Ma	arylan		artmen <i>tificate</i>			and M	_	giene Reg. No	010	285	547
	hysicia		1. Decedent's Name (First, Middle, Last)  David			Wi	lson				2. Date of De Month	Day	2010	3. Time o	
	/Medic xamin		4a. Facility Name (If not institution, give s The Johns Hopkins Ho	spital			,	nore	City  If Under		Date of Bir		inty of Death	Land (Charles)	
Dire	neral ector		5. Social Security Number  218–28–8261  Usual Residence of Decedent	M 2 🗆 F	78 (In yrs. I	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da AUG . 2	ay, Year)	Cour	place (State of htry) NC	or Foreign
ne Maryland	tified at	Director	10a. State 10b. County		ĺ	y, Town or Lo	E								City Limits
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	in term 2.7 is marked other train matural, or nems 2.54 or 264-1 show or other traumatic event, the Medical Examiner must be notified at	by Funeral	10e. Street and Number  1022 E BIDDLE ST  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent B Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:			10f. Zip  212  Was Deced f Yes, spec	202 lent of His ify Cubar	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No dican, etc.)	USA 14.	of What Countries  Race - Americ Black, White, ecify: BLA	can Indian, etc.	
d 21215-0036 filed within 72 hours aft Hygiene.	the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12TH		+)	life. L		rk done d e retired)	uring most			CIT	of Business/Ir	,	ORE
Maryland d 2 should be file th and Mental Hy	umatic event,	To Be (	17. Father's Name (First, Middle, Last)  WARDELL SHAVER  19a. Informant's Name/Relationship (Type)	ө. Print)		19b. Mailin	ig Address		NEI	LIE	(First, Middle WILSON I Route Numb			Code)	
altimore, Marit. Pages 1 and 2 apartment of Health a	y or other tra	3	KATHY DAVIS  20a. Method of Disposition  1   Burial 2   Cremation 3   Red 4   Donation 5   Other (Specify)	emoval from State	20b. P	102 lace of Dispo emetery, cren	sition (Nan natory or o	ne of	)	Da	BALTIMO ate 3/2010	20c. Locati	on - City or To	own, State	
Baltimo permit. Pag Department	any Injury o		21. Signature of Funeral Service Licensee	aus S	the death	22	. Name an	7-09	s of Facility  EASTE	WES	CLEY CH	AVIS,	JR. F	IRL. HI	31
te N	he burial-transit	tamii	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	tatic a consequ a consequ	uence of): uence or):	sition	al a	cel	carci	noma	-		Interval Ber Onset and	Death
O. Box 68 he death certific the attending pl	for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ac. If yes, outcome of the line of the lin	2 - Fetal	death 3	Ectopic p Other (sp					23d.	Date of deliv Month	ery Day	Year
ecords, P.O. Bo law requires that the death as been signed by the atten	pe d	2	Part II. Other significant conditions cont	tributing to death bu	ut not resi	ulting in the u	nderlying	cause give	en in Part I	l.	23e. Did 1		contribute to		
T e e	page 2	Completed	CHF								24a. Was autop perfo		4b. Were auto prior to co death? 1  Yes	ompletion of	available cause of
VITA slclan; certifica	director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatier	nt 2 🗆 I	ER/Outpatient	: 3□ DO	LOther			(Check only o		Other (Special	iv)	
FOR OT adding Physical After this of the control of	e funeral c	ation: To	27. Manner of Death  1   ↑ Natural 5   Pending  2   Accident investigation	28a. Date of Injur (Month, Day	у	28b. Time of Injury		Bc. Injury Work?	at	2	8d. Describe			,,	
DIVISION OT VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	. (Specify)	)					8f. Location ( City or Tow	vn, State)			nber,
e Hospi 24 hou e Funer	completely filled	edical	29a. Certifier 1 Certifying Physi (check only one) 2 Medical Examin	cian: To the best of er: On the basis of end manner sta	examinati	vledge, death ion and/or inv	occurred estigation	at the time in my op	e, date and inion, deat	d place, a th occurre	nd due to the ed at the time.	cause(s) and date and pla	d manner as a ace, and due	stated. to the cause	(s)
To the within To the	dwoo	Me	29b. Signature and title of certifier  Mee 49	ve, M	D	•	29c	RES	number	)		29d. Date sig	gned (Month,	Day, Year)	
	9		30. Name and address of person who co		eath (Item	1 23a) (Type, I	Print)			600 N	orth Wo	olfe St. I	Baltimo	re, MD.	21287
	Stat	G	31. Date filed (Month, Day, Year)	32. Registrar	s Signat	re and						,		, , , ,	

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

amend State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. N. ? | | 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sep 3, 2010 Month Physician/ 5:30p Oscar M. Walker, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbus Columbia Drive N/A Baltimore 3629 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 1 🙀 M 2 🗆 F Months Days Hours Min Maryland Director Apr 8, 1937 219-28-3439 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 ☐ No Baltimore N/A Maryland 10e. Street and Number bus 10f. Zip Code 10g. Citizen of What Country? by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumas". U.S.A 21215 3629 Gelumbia Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 🙀 Married 1954 1 ☐ Yes 2 🗓 No Specify: Specify Black Completed 3 Divorced 4 Divorced Year or Dates 1958 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Private Company Elementary/Seconday (0-12) Steel Worker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rosie Walker Loaring -Lorarine Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3629 Gelumbia Drive Baltimore, Maryland 21215 Ernestine Walker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🙀 Burial 2 🗆 Cremation 3 🗀 Removal from State Crownsville, Md. 09/13/10 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery 22. Name and Address of Facility Signature of Funeral Service Licensee Estep Brothers Funeral Service, P. A Eutaw Place Baltimere, Md 23a. Part 1. Enter the 1t ease, or complications that call ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TRUST disease or condition resulting in death) Medical Due t (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 2 **X** No Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ~MD 6095 Marshalee Dr. Flkridge, MD 21075 arrism Charles M. 31. Date filed (Month, Day, Year, 32. Registrar's Signature State SEP 1 0 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MILDRED WOODZELLE 5 ISAM 2010 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN BALTIMORE HOSPITAL BALTIMORE 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 215-18-5632 1 M 2 V Min 97 Director Usual Residence of Decedent 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location GOOD SAMARITAN NURSING Director HOME, BALTIMORE MD BALTIMORE CITS 1 Ves 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1601 BELVEDERE MENUE UNITED STATES 21239 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. WHITE 3 ₩idowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Exxon Stenographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer August Kreider Addie Lenorn Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Theresa Venson / Friend 245 Attenborough Drive Apt.302 Rosedale, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 9/08/2010 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Rd Marondria J. Blow Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death SEPSIS | SEPTIC SHOCK Physician, SEVERE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 5 days DIFFICLE COLITIS Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ RENAL FAILURE Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s page 2 s performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖰 No 1 🗌 Yes 1 Dimpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MROBS (PESIDENTI) RES 000 915/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DENYSE MTCHMANSINCH, 90 GOOD SAMARITAN HOSP, STOLL HOCH RIVER
ISN O 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Watson Marion Naomi Sept 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Health and Rehab Ellicott City Howard Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month Day, Y 1 M 2 X F Hours Min Director Marvland 219-26-8122 69 Nov. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Lindsay Road 21229 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Secretarial/ Management Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Triplett Martin Warrenton Helen May Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Watson, Son 4900 Lindsay Road, Baltimore, Maryland 21229 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Carcemation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/8/2010 Baltimore, Maryland 21. Signature of Juneral Service License Amanda Heaston 22. Name and Address of Faciliteremation Society of Maryland, 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Pregnant at time of death Day Year 5 Other (specify) signed by the ar Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autonsy performed? Yes 2 🔀 No 1 Yes 2 No Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 💢 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗶 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) 24 hours after death.
Funeral Director: After this the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 Tyes 2 🗌 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month)

ember 9

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MD

2010

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Alexander Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28551 Certificate of Death Last) 2. Date of Death Physician/ September 7. Dolores A. Waters 2010 10:30pм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brinton Woods Health Care Sykesville Carroll Co. If Under 1 Year If Under 24 Hrs 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Hours 2 Month, Day Year 88 Director 214-16-8786 Usual Residence of Decedent 10a State 10b. County with the Maryland 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f MD N/A 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 155 S. Grundy Street 21224 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or than "natural", or iter the Medical Examiner 14. Race - American Indian ģ 1 Never Married 2 Married Black, White, etc. 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " College (1-4 or 5+)
N/A Elementary/Seconday (0-12) Sales Clerk Hausner's Be 17. Father's Name (First, Middle, Last) and Mental Fish marked of 18. Mother's Name (First, Middle, Maiden Surname) ၉ John A. Ellerbrock Mary Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Frank M. Waters - Son 3046 Sykesville Road Westminster, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9-8-2010 Baltimore, MD 21. Signature of Funera Service License 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events CENTRICATION APPROVED BY MEDICAL BY resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day signed by the a g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed nas page 2 certificate Be ၉

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or

Division of Vital Records, P.O. Box 68760

	1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 💢 Unknown
	24a. Was an autopsy performed? 1 □ Yes 2 ♣ No 1 □ Yes 2 □ No
25. Was case referred to medical exampler? 26. Place of	of Death (Check only one)
1 Ves 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other:	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
28a. Date of injury 28b. Time of 28c. Injury at injury 28b. Time of 28c. Injury at work?	28d. Describe how injury occurred 28No Fell from Standin, Position
4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  9 → Home	28f. Location (Street and Number or Tural Route Number, City or Town, State)
29a. Certifier (Check only one)  1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date 2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead only one)  3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time	e and place, and due to the cause(s) and manner as stated.  eath occurred at the time, date and place, and due to the cause(s) and manner state

29c. License number

D62786

State Registrar

Certificate:

Medical 2

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Vento, Thomas M.D.

114 Business Center Dr. Reisterstown, MD

29d, Date signed (Month, Day, Year)

9-8-2010

31. Date filed (Month, Day, Year) 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 8 2010 Margaret Ν. Yeoumans Р 6:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours 01/27/1912 212-40-6524 98 Baltimore, MD Director Usual Residence of Decedent show 10a. State 10b. County items 23a or 28a-f shoner must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No PA Seven Valleys York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 828 Lake Redman Court 17360 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked or ပ Finn Katherine Jerome Nixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. SEPTEMBER 828 Lake Redman Court, York, PA 17360 Peggy Kirk/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗆 Other (Specify) 09/13/2010 Dulaney Valley Mem. Timonium, MD 22. Name and Address of Facility Towson, MD\_21204 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical certificate be VECUMANS, MARGARET Division of Vital Records, P.O. Box 68760 attending p for use as t 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Live Birth 2 Fetal death Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No or Attending Physician: The 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

ERNESTINE WRIGHT, 31. Date filed (Month, Day,

Mes

INP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

2300 DULANEY VALLEY ROAD M.D

29d. Date signed (Month, Day, Year)

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MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** September Z. 1703 2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HO 40 8. Date of Birth (Month, Day, June 20, 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday)
20 Yrs. 9. Birthplace (State or Foreign Funeral Months Days Hours Min 1**X**M 2□ F 215-29-2349 Director Baltimore, MD Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Hydical Examinating the modified anone. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Edgewood Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1229 Windy Branch Way 21040 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕍 No Specify: Specify: Chinese þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wei Yu Mei Wu ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Janssen (Foster Mother) 1229 Windy Branch Way Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel

Air 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State Sept. 08,2010 Forest Hill, Maryland 4 Donation 5 Dother (Specify) Signature of Funeral Service Ucensee Tiffany Cohn 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Onset and Death Physician Cardiac disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Respirator Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Lang Syndrome 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Quadriplegia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Vital 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🕽 25. Was case referred to medical examiner?
1 XYes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this 28a. Date of Injury (Month, Day, Year) 27. Inner of Death
1 X Natural
2 Accident 28b. Time of al or Attending P safter death. I Director: After t After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 37908 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 836 South Main St Suite 102 Forest Hill MD 21104 Lononic MD 32 Registrar's Signat Ch 31. Date filed (Mont) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr g907 9-10-10 vt
State of Maryland / Department of Health and Mental Hygiene 28554 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 1, 2010 Physician/ 9:45 a.M Zollinhofer Donald Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset 23124 Soundside Estate Rd. Deal Island 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Mar. 28 Year 1915 Days Min. 1 🔀 M 2 🗆 F 95 Director 578-03-8127 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 X No Deal Island MD Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21821 United States 23124 Soundside Estate Road Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No WW II Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Automotive / Airplanes Mechanic item 27 is marked other other traumatic event. th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ၉ Elizabeth Susan Gough Walter Duncan Zollinhofer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9024 Treesdale Dr. Easton, Maryland 21601 Daniel Donald Zollinhofer (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept Date 01, permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Burial 2 Cremation 3 Removal from State Bethesda, Maryland Uniformed Services Univ. 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ DION Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital ၉ 1 Yes 2 XXV 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1XXNatural injury 5 Pending 2 Accident
3 Suicide Investigation Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Directory filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 2011 Mg 31. Date filed (Month, Day, Year. State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lumas 2010 3.35 PM Medical 20th mbe 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death Bayview Medicallent Johns Hobkins If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-30-6569 1 🖳 M 2 🗆 F Months Days Hours 79 Feb6, 1931 Pennsylvania Director Yrs Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 603 Umbra Street 21224 U.S.A. items 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Zoumadakis Helen Jamariudakis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John & Katherine Zoumadakis permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 603 Umbra Street Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State September cemetery, crematory or other place, 4 Donation 5 Other (Specify) 9.2010 rownsville V. <u>|Crownsville</u> 21. Signature of Funeral Service 22. Name and Address of Facilit Kaczorowski Funeral Home, Ρ. Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or a a consequence o Examiner Cell carcinoma tastasi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature RES-OOC Name and address of person who completed cause of death (Item 23a) (T) 23a) (Type, Print) trenue. Pas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

1- State Registrar

State Registrar

State A Maryland / Department of Health and Maryland / Department of Health / Department of Health / Department / D Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 08-29-2010 **Physician** Frances Josephine Amasia 7:45P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2823 Cross Country Court Harford Fallston If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
10-21-1918 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 91 220-38-7316 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Iteme 2020 any Injury or other traumstin 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 ☐ Yes 2 No Director Harford Fallston 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2823 Cross Country Court 21047 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Catholic High School 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Esposito Maria Veniero ၉ 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 Oakmont Rd Fallston, MD 21047 Andrea Amasia 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐Other (Specify) Encombmen Parkwood Maus. 09-02-2010 Parkville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Rd Nottingham, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acura Physician KAN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SESTIUE Sequentially list conditions to lor as a consequence of): Examiner cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last The law requires that the death certificate be executed signed by the attending physician and deeq be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE N 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 2 No 3 ☐ Probably 4 ☐ Unknown EL L Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 autopsy page certificate 1□ Yes MENTI the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of funeral Certification: 5 Pending investigation Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 24 one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SA 21+1N 1 LVACION 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 420m 28557 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>Alexander Borawick</u> Medical 2010 August 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 0 5669 Gunpowder Road White Marsh Balto. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) October 5. **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours Director Yrs. 219-30-1997 Marvland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Md. Balto. White Marsh 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 5669 Gunpowder Road 21162 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) س Pe filed س realth and Mental Hygie. m 27 is marked other th r traumatic وهه--' Captain Tug Boat Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Department of Health and Menta Important if item 27 is marked any injury or other traumant. 2 Ilarion Borawick Serafina Vasilievna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadine Borawick 5669 Gunpowder Road White Marsh, Md. 21162 Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Trinity Russian 9-4-2010 Elkridge, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 010 Interval Between Immediate Cause (Final KINSONISM Physician Onset and Death disease or condition Medical resulting in death) r as a consequence of): Examiner KOTATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 0 Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ERMINER VASCULAR Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 48025 8/311 Gw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) By En ( M) Q 1224 40000 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28558 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Charles September 10. Medical Ralph Beltz 2010 8:50 AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5005 Shirleybrook Avenue Rosedale Baltimore 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🌠 M 2 🗆 F Days Months Min. Hours (Month, Day, Year, 4/10/1919 Country **Director** 202-10-2578 Pennsylvania Usual Residence of Deceden show at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f sh notified a 1 Yes 2 No Maryland Baltimore Rosedale ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 5005 Shirleybrook Avenue 21237 S. A. permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural may injury or other than "natural". 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 1 Yes 2 No Specify. 3 Divorced 4 Divorced Completed White Decedent's Usual Occupation
 Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Maintenance Technician</u> Steel Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell Beltz Cora Bretney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Catherine Beltz (Wife 5005 Shirleybrook Avenue Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3618 4 ☐ Donation 5 ☐ Other (Specify) of Faith Mem. Overlea, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home PA Bruzdzinski Funeral Home 1407 Old Fastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ DIVECTION Onset and Death disease or condition Medical resulting in death) Due to ( as a consequence of Examiner stay Signantially list or actions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events soulding in death). Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2X No 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 욘 1 Inpatient 2 ER/Outpatient 3 DQA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending injury Accident hours after death uneral Director: / Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, the Hospital within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number -26434

DHMH 17 Rev 7/2009

State Registrar AKTHUR

405 Digital Drive

d cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Manth Physician/ 20°10 7:58LAJUAN D. BEAVER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE SOUTHERN MARYLAND HOSPITAL GEORGE'S CLINTON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 3775 Pay 1960 WASHINGTON DO 578-76-2216 50 Yrs. **Director** Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director DC WASHINGTON 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe "natural", or items 23a 20020 UNITED STATES 2104 SUITLAND TERR. S.E. #202 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. <u>ک</u> 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Yrs NURSING ASST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ MARY F. BEAVER ALVIN MATHIS 1 and 2 should to of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $8\,0\,6\,$  AVANTI PL., HYATTSVILLE, MD.  $2\,0\,7\,8\,5\,$ TIKECIA JOHNSON/DAUGHTER or other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1. Department of I Important: If its any injury or or ō 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREM. 9/13/2010 BELTSVILLE, MD 4 X Donation 5 Other (Specify) we of Funeral Service Licen 22. Name and Address of Facility CAPITOL MORTUARY AVE NE <u>MARYLAND</u> 23a. Part 1. Enter the dise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Hart 1. Enter the discharge shock, or heart failure. st only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** 00 KI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a Examir and -transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t performe 1 ☐ Yes 2 ♣ No certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ပု 1 Inpatient 2 KER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify, this Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tyes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined after To the Hospital o within 24 hours aft To the Funeral Di completed filled in 1
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in magnification in magnification in magnification. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a s of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Registrar's State SEP 132010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 5 per fh g907 9-21-10 yt
State of Maryland, Department of Health and Mental Hygiene
item 17 per fh g908 10-18-10 yt
Certificate of Death

Reg. No. amend item 17 per For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** September 8, 2010 10:20A M Ruth A . Braun /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Pasadena 250 Kentucky Ave. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 219-20-**6792** Days Hours Min 1 ☐ M 2 🛱 F Months Yrs. June 14, 84 1926 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Pasadena Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò IISA 5161 Mountain Rd. 21122 items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ò 1 ☐ Yes 2X No White If Yes, Give Year or Dates: Specify. Specify: δ 3 ☑ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Household 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fruince Adams Rachel Pannell Irving ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1503 Shipsview Rd. Annapolis, Md. 21409 (Son) of Health a Wayne Braun other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of IImportant: If ite
any Injury or ot 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Pasadena, Maryland Carmel U.M.C.Cem. 9/14/10 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home PA 21. Sigr ature of Funeral Service lice 3111 Mountain Rā. Pasadena, Mā. 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or conshock, or heart failure. List only hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 20 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient ဥ this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, director, page 2 s death. nours after death.

neral Director: /
filled in by the f within 24 hours a

To the Funeral C

completely filled i 5

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Da

(Check only one)

29b. Signature and title of certifier

028

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September Physician/ Alexander N. Chrisikos 1:00 A. M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 406 Homewood Road Anne Arundel Linthicum 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 1 X M 2 □ F Months Days Hours 09/09/ 218 26 2331 80 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Anne Arundel Linthicum 1 Yes 2 X No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 406 Homewood Road 21090 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes. Give 3 Divorced Completed Year or Dates. WW II White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Merchant Elementary/Seconday (0-12) College (1-4 or 5+) Self employed Cross St. Market 12th permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Nicholas Chrisikos Violet Makris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Homewood Road Linthicum, Maryland 21090 Yvonne Chrisikos / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 D Burial 2 X Cremation 3 D Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/07/2010 Signature of Frineral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician nd disease or condition resulting in death) Medical Due to (or as a cons duence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X10 1 Tyes 2 4 \( \square\) Nursing Home 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence 6 Other (Specify Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital c 24 hours a To the Hospital within 24 hours To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

State Registrar 1401 Madison Park

Glen Burnie, Maryland 21061

and address of person who completed cause of death (Item 23a) (Type, Print)

NUSaired

. Registrar's Signat

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State of Ma	aryland / Depa <i>Cer</i>	artment of Health and tificate of Death		ene 2010	28562
Physici		Decedent's Name (First, Middle, Last)     JOHN DESMOND CORCORAN			2. Date of Death September	r <sup>™</sup> 8, 20¶0	3. Time of Death 7:20A M
Medi Exami		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Deat		4c. County of Deat	h
Funeral		Northwest Hospital Center  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Randallstown  If Under 1 Year   If Under 24 Hrs  Months   Days   Hours   Min	8. Date of Birth	Baltimo	thplace (State or Foreign
Director		233-80-5051 1 X M 2 G F Usual Residence of Decedent	74 Yrs.	Months Days Hours Mill	October 3,	f935   I re1	and
aryland a-f sho	ctor	10a. State 10b. County	10c. City, Town or Loc				10d. Inside City Limits 1 ☐ Yes 2 🌠 No
the Ma a or 28% be notii	Dire	Maryland Baltimore  10e. Street and Number	Owings Mi	10f. Zip Code	10	g. Citizen of What Co	
eath with ems 23 r must	Funeral Director	4205 Sihler Oaks Trail  11. Marital Status 12. Was Decedent Ev	ver in U.S. 13. W	21117  Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	pecity Yes or No-	USA 14. Race - Ame	rican Indian.
and 21213-0036  be filed within 72 hours after death with the Maryland antal Hygiene.  ked other than "natural", or items 23a or 28a-f show c event, the Medical Examiner must be notified at		1 Never Married 2 X Married  Armed Forces 2  1 Yes 2 X If Yes, Give	lo.	Yes, specify Cuban, Mexican, Puer Yes 2 No Specify:	to Rican, etc.)	Black, White	
Z1Z15-UU36 within 72 hours after giene. er than "natural", o the Medical Exam	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation ind of work done during most of wo	rking	6b. Kind of Business	
within 7 yiene.		Elementary/Seconday (0-12) College (1-4 or 5-	life. DC	NOT use retired)  er/Coach		Private S	School
	To Be	17. Father's Name (First, Middle, Last)  Joseph Corcoran			me (First, Middle, Ma hnston	iden Surname)	
Mary  2 should th and Me 7 is mar  traumati		19a. Informant's Name/Relationship (Type, Print) Kathleen Marie Corcoran	Wife 4205	g Address (Street and Number or Ri Sihler Oaks Trai		ity or Town, State, Zip Mills, Mar	ryland 21117
baltimore, I permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1₄□ Burial 2 M Cremation 3 □ Removal from State	20b. Place of Dispos	atony or other place)		Oc. Location - City or	
<b>SAITIMOFE</b> , cermit. Page 1 and Department of Hee Important: If item any injury or othe once.		☐ Donation 5 ☐ Other (Specify)  21 Signature of Funeral Salvice Licensee		Crematory 09/1		altimore, feld Funer	
any per any gar	L	Dinnis Disten Jewey	(2) 6	500 York Road Ba	ltimore,	Maryland 2	
Physician/		23a. Part 1. Enter the dise ye, or comply all ns that caused shock, or heart failur. List only ye cause on each line. Immediate Cause (Final disease or condition ASCVD	the death. Do not ente	r the mode of dying, such as cardia	c or respiratory arrest		Approximate Interval Between Onset and Death
Medical Examiner		moulting in death)	consequence of):				
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a	consequence of):		-		
rou icate be executed I physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a	consequence of):				
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certifica ending p		IF FEMALE: 23b. Was decedent pregnant in the post 12 months?  23c. If yes, outcome of 1 □ Live Birth 2	of pregnancy	Ectopic pregnancy		23d. Date of del	ivery
y F.C. BOX 08/19 set that the death certific igned by the attending to be detached for use as	Physician/N	in the past 12 months?  1  Yes 2 No 9 Unknown  1  Ves 12 No 9 Unknown		Other (specify)		Month	Day Year
s that the igned by be deta	by	Part II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause given in Part I.		cco use contribute to	
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The lav	Comp				autopsy perform 1 🗆 Yes 🐧		completion of cause of
VICAL yslcian: is certifi director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No 1  Inpatie	nt 2 <b>X</b> XER/Outpatient	26. Place of Death (Che		ce 6 Other (Speci	ify)
ding Ph h. After thi funeral		27. Manner of Death  1 ★ Natural 5 □ Pending  28a. Date of injury (Month, Day,	/ 28b. Time of	28c. Injury at work?  M 1  Yes 2  No	28d. Describe how		
JUNESION OF all or Attending P. s after death. Il Director: After the ed in by the funera	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injur	y - At home, farm, stre (Specify)		28f. Location (Stree City or Town, S	et and Number or Rur State)	ral Route Number,
DIVISION ON VICAL RECORDS, P.O. BOX OS To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical (	29a. Certifier 1 XX ertifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of ex-	amination and/or investi	gation, in my opinion, death occurred	at the time, date and	place, and due to the c	cause(s) and manner stated.
To the within 2 To the comple	ž	29b. Signature and title of certifier	est of my knowledge, di	29c. License number		d. Date signed (Month	
		20 Normal addition of	oth //tom 00=\ T	D0062650		9/8/10	
			Old Court F	Road Randallstowr	n, Marylan	d 21133	
Sta Registr		31. Date filed (Month, Day, Year) SEP 1 3 2010	's Signature	Ke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	- 10.11			Certific	ate of	Death				5	Reg. N		110	2836
Physicia	ın/	1. Decedent's Name (First, M	iddle,Last	)								2. Date of D Month	Day	/ Yea	ar	3. Time of Death 0017 hrs
Medical Examir	ner	LeVern  4a. Facility Name (if not instit		onta estreet and nu	mber)	Domi	neys		vn or	Location of	of Death	Septem		2010 4c. County	of Death	
		University Hospital	a, g					Baltime						N/		
Funeral		5. Social Security Number	6. Se	×	7. Age (I	n yrs. last birt	hday)	If Under			r 24Hrs.	8. Date of	Birth(M			hplace (State or
Director		217-25-6865	1X	M 2 F		20	Yrs.	Months	Day	s Hours	Min.	10/1	15/1	989		untry) MD
'n		Usual Residence of Deceden 10a. State 10b. Cour			110	c. City, Town	or Locatio	n .								10d. Inside City Limits
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r death with the Maryland or items 23a or 28a-f show any must be notified at once.	eral	11. Marital Status		12. Was Dec	edent Ev	er in U.S.				spanic Orig		ecify Yes or	No-		- Americ e, etc.	can Indian, Black,
r deat	Funeral		Married	1 Yes	2 <b>X</b>	No		_				trount, etc.,		1	•	ale
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sh al Examiner must be notified at once	Ē	3 Widowed 4 15. Decedent's Education (		or Dates:			Decedent'	s Usual Oc	cupat	specify: tion (Give I			16b	Specify: . Kind of Bu		
72 hou "nai	Completed	Elementary/Secondary (0-	12)	College (1	-4 or 5+)		during mo	st of workir	ng life.	. DO NOT	use retire	ed)				
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imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (First, Mid										First, Middl yn Do		en Surname	)	
212 212 Ments Ments mark	e e	Robert Johr 19a. Informant's Name/Relati		/pe, Print )		198	o. Mailing	Address	-					City or Tow	n, State,	Zip Code)
MD 42 sho th and 1 27 is		Gwendolyn D	omne	eys(mo	the						st					21217
s l and file transition of the second		20a. Method of Disposition  1 X Burial 2 Crema	tion 3	Removal fr	om State	20b. Place of cremate	of Disposit ory or othe		of cer	metery,		Date	200	c. Location -	City or 7	Town, State
Page ment of tant:		4 Donation 5 Other	Specify:	_		King								3alti		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		21. Sign ture of Funeral Serv	ice Licen	ee ()	10	^)	22_Na	sep1	idress H	of Facility	own	Jr.	FUI	neral	. Ho	me PA 21217
Physician	-	23a. Part I. Enter the disease			aused the	death. Do no										Approximate Interval
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that thrs after death.  14 Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	Ä.	27. Manner of Death		28a. Date (Month Sep 3, 2	of Injury Day Year)	28b. 2212	Time of In	ury 280		ry at Work	0	28d. Descrit Subject s		njury occurr	ed	
Sior Attend death death sctor:	catic	H	ending vestigatio	on				(======================================		res 2	No			and Nivers	an an Dun	al Davida Number City
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Divisior Hospital or Attend 24 hours after death Funeral Director: etely filled in by the 1		20a Cartifies	Physicia	an: To the bes		nowledge, dea	ith occurre	ed at the tin	ne, da	ate and pla	ice, and d	lue to the c	ause(s)	and manner	as state	d.
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 Medical I		On the basis of and manner s		ation and/or i	nvestigatio	on, in my op	oinion	, death occ	curred at	the time, da				
	Σ	29b. Signature and title of cer	tifier	, \(\)						e number						th, Day, Year)
		( larla	en	10)		h /lin 00			D.C.I	IVI. □.			36	eptember	7, 20	
7		Laron Locke MD.		ompleted caus ant Medica			Penn	Street, E	Baltin	nore, MI	D 2120	1				
		31. Date filed (Month, Day, Ye	ar)	82. Re	gistrar's	Signature										
Regist	rar	SEP 13	2010	Denne	4	1. 13	arke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Rita R 3:12 Edwards September 2010 \*/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Baltimore Medical Center Mercy

5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 F Director 216-18-9041 86 July 31,1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Tyes 2 No Director Md. Balto. Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or: 8620 Kelso Dr. Apt.A315 21221 USA Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Sam L. Shapiro & Sons 2 College (1-4or 5+) Elementary/Secondary (0-12) Administrative Secretary Import & Export Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard J. Dembeck Pauline Feda ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any Injury or other traconce. Rosedale, Md. 21237 Paula Reber DTR. 4702 Bucks Schoolhouse Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus 9-13-2010 Balto. Md. 4 □ Donation 5 □ Other (Specify) 21. Signature in Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Severe Decompensated Hortic Stanosis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Artery if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the aid be detached for 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 dunknown Hypothycoidism Hyperlipidemia Hypertension. 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No lung concer certificate 2000 Cyber Knife 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 Mo Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1, npatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P25645 September 8,2010

31. Date filed (Month, Day, Year) State Registrar

Roger

32. Registrar's Signature

Paul

Saint

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301

DHMH 17 Rev 1/2001

Place

Baltimore, MD 21203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28555 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav September 2010 7:10 В Eldridge Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mitchellville Prince George's Villa Rosa If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug . 17, 1 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 🗆 M 2 💢 F 1926 Virginia Director 84 62-22-6769 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Hillsdale Bergen 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 380 Piermont Avenue **Examiner must** 07642 USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or i 1 Never Married 2 Married þ 1 ☐ Yes 2 ☒No Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. 3 Widowed 4 Divorced Completed Black Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Federal Government Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry F. Brent Mattie V. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelia R. Eldridge/Daughter 380 Piermont Avenue, Hillsdale, NJ 07642 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery crematory or other place)
Rethel Raptist
Church Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sep.13,2010 Amissville, 21. Signatury of uneral Service Licensee 22. Name and Address of Facility Joynes Funeral Home, Inc. PO Box 3633, Warrenton, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death ADVH Physician/ Ai 20 Medical resulting in death) Due to (or as a consequence of): Examiner 20 SLUIAr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). sician and burial-transit Cause (Disease or linjury that initiated events rote Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 0 in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Yes 2 X No the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be detent 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 X No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify)

P.O. Box 68760 Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Be မ Certificate: Medical

27. Manner of Death

X Natural

4 - Homicide

29a. Certifier

29b. Signatu

(Check only or

Accident

Suicide

5 Pending

Investigation 6 Could not be

State Registrar

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nufse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of de 29c. License number 29d. Date signed (Month, Day, Year)

3226

28c. Injury at

work'

1 Yes 2 No

28d. Describe how injury occurred

8

2010

0

30. Name and address of pers who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

Richard Jay Feldman, M.D. 8116 Good Luck Road, Lanham, MD 20706

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

32. Registrar's Signature

the

Please Type or Print in Black incellible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First\_Middle\_Last) 2. Date of Death Physician/ Month Year 2010 Bertha A. 6:408 Elton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2NOT 29 TIMOS If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
4 / 1 6 / 1 9 1 Social Security Number g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2 💢 F Months Country) 100 Director 218-22-5139 Marvland Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director or other traumatic event, the Medic of Examiner must be notified 28a-f 1 🗌 Yes 2 🔀 No MD Baltimore Catonsville 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 707 Maiden Choice Lane 21228 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or i þ 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify. Completed 3 X Widowed 4 □ Divorced USA Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Trust Officer Banking 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Fisher Etta Anderson and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Maureen DiLaura / Daug. 843 Harmony Way, Centreville, Maryland 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or of once. 1 

Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 9/15/2010 Baltimore, Maryland 2 Signature of Funeral Service Lie 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final Physician/ OSC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 No this certificate has Hospital or Attending Physician: The I 24 hours after death. 2 🗌 No 1  $\square$  Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 28b. Time of Certificate: 28d. Describe how injury occurred Director: After Naturai 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certific 29c. License number no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 401ce

DHMH 17 Rev 7/2009

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	e of Maryland		rtment of H tificate of D			2.0	10 28567
			Registrar  1. Decedent's Name (First, Middle, Last)	, —	OCI	incate of B	T	2. Date of Death	g. No.C. U	3. Time of Death
	Physicia Medic		Vanes 5. Edwar	4)1				Estent's		Year 2:00.4M
	Examin	ier	4a. Facility Name (if not institution, give street and 202 Customs Way	( number)		4b. City, Town, or I	ocation of Death.ersville		4c. County of Anne	of Death Arunde1
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthplace (State or Foreign
	Director		242 28 7850   1 M 2 L  Usual Residence of Decedent	<sup>F</sup> 85	Yrs.	Months Days	, louis Iviii.	08/16/	7925	North Carolina
	land show	tor	10a. State 10b. County		Town or Loc				-	10d. Inside City Limits
	e Mary r 28a-i notifie	Direc	Maryland Anne Arund	el M	illers					1 ☐ Yes 2 🛣 No
	with th 23a o st be	Funeral Director	202 Customs Way			10f. Zip Code	.108	10	g. Citizen of W U.S.	
	items items		11. Marital Status 12. Was Arme	Decedent Ever in U.S.	13. W	/as Decedent of His Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto F	ify Yes or No-		- American Indian,
330	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 If Yes	Yes 2 🔼 No s, Give or Dates.	l l	☐ Yes 2 No		, ,	Specify:	White
5	2 hours "natur idical I	Completed	15. Decedent's Education (Specify only highest grade comp			ent's Usual Occupa	tion uring most of workin	g 1	6b, Kind of Bu	siness Industry
9500-61212	ithin 73 ene. r than the Me	Com		ge (1-4 or 5+)	life. DC	NOT use retired)	_	9	Railr	road
ō	filed w al Hygi I other vent, 1	a	17. Father's Name (First, Middle, Last)				18. Mother's Name		iden Surname)	)
Maryland	should be filed with h and Mental Hygier 7 is marked other t traumatic event, th	욘		k Edwards				Claris	e Robir	nson
Z	2 shoulth and lith and 27 is n		19a. Informant's Name/Relationship (Type, Print)  James Edwards Jr. /	Son		g Address (Street ar Customs W	nd Number or Rural av M			ate, Zip Code) aryland 21108
Č.	of Hea of Hea fitem		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal	20b. Pla	ice of Dispos	sition (Name of atory or other place	. D			City or Town, State
Baltimore,	t. Page tment tant: I tant: I		4 ☐ Donation 5 ☐ Other (Specify)		n Have	n Mem. Pa	rk 09/0	7/2010	Glen Bu	rnie, Maryland
pai	permit. Page 1 and 2 should be for Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evente.		21. Signature of Frineral Service Licenses	ridge	12	Name and Address	001			rvice, P.A. Maryland 21225
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death.						Approximate Interval Between
*	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)			1 ROCH	TNE	4RC712		Sheet and Death
لممدر	Examiner			e to (or as a conseque	nce ot):					
-	p #s	Examiner	cause. Enter Underlying	e to (or as a conseque	nce of):					
	kecuter and al-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	e to (or as a conseque	nce of):					
2	cate be executed physician and the burial-transit	edical	<b>L</b> d	<u></u>						
200	artificat ding ph		IF FEMALE:	, outcome of <u>pr</u> egnance	24					
XOR	Attending Physician: The law requires that the death certific ar death.  **T death.** After this certificate has been signed by the attending pector. After this certificate has been signed by the funeral director, page 2 should be detached for use as	by Physician/M	in the past 12 months?	Live Birth 2  Fetal of Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery oth Day Year
5.	t the d by the stacher	Phys	9 Unknown 9 U	Unknown	4i i 4b		- i- D-+	T.,		
λ, J	ires tha signec d be de		Partii. Other significant conditions contributing	to death but not resul	ung in the ti	idenying cause give	mm Parti.			bute to the cause of death?  3  Probably 4 Unknown
Vital Records,	w requ s been 2 shoul	Completed						24a. Was an		Vere autopsy findings available
rec	The la cate ha page 2	Com						autopsy performe	ed?	rior to completion of cause of eath?
Ea	sician: certific rector,	) Be	25. Was case referred to medical examinor.  1 Yes 2 No Hospital:			Other	ce of Death (Check			
0	ig Physer this neral di	te: To	27. Manner of Death 28a.	1  Inpatient 2 E  Date of injury 2  (Month, Day, Year)	R/Outpatient 8b. Time of injury	28c. Injury	_4 □ Nursing Hon at 2	ne 5 Residen 8d. Describe how		
0	tendin Jeath. tor: Aft the fur	Certificate:	2 Accident Investigation				es 2□No			
DIVISION	Il or At after of Direct		4 Homicide determined 28e. I	Place of Injury - At hom pullding, etc. (Specify)	ie, farm, stre	et, factory, office	2	8f. Location (Stre City or Town,		r or Rural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  Ot the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier Check 2 Medical Examiner: On the	the best of my knowled	dge, death o	ccured at the time,	date and place, and	due to the cause	(s) and manne	r as stated. to the cause(s) and manner stated.
	o the lathin 2, o the lathin 2, o the lathin 2, omplet	Me	only one) 3 Certifying Nurse Practic  29b. Signature and title of certifier	ner: To the best of my l	knowledge, d	eath occurred at the 29c. License	time, date and place	, and due to the ca	ause(s) and mar	nner as stated. (Month, Day, Year)
	⊢≶⊨ő		1 02	170						
	1.1		30. Name and address of person who completed	cause of death (Item 2	(Type, Pr	rint)		7 10		1/2010 My/ol 2100
	€ V Stat	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	te Lie	17. long	7 6km	on Du	nee	keylout -100
	Registra		SEP 1 3 2010	upu B.	par					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 55. P Day Year 1802 M Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard Columbia CANN If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F (Month, Day, Year) Apr 7, 1946 Country) 579-58-5961 64 W. VA Director Yrs Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 7724 Chatfield Lane 21043 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black, White, etc. 12/10/19 1 Never Married 2 Married Completed by 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9/27/1972 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mail Handler **US Post Office** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Edward Ferrell Bernice Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Ferrell spouse 7724 Chatfield Lane Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery 20c. Location - City or Town, State Date injury or Cremation 3 Removal from State Sep 30, 2010 Arlington, Virginia Donation 5 Other (Specify) Funeral vice Licenses 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death sho ck, or heart failure. List only one cause on each line. ate Cause (Final Physician/ e or condition ng in death) UMINANT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, day, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examir Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi PATITI that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the detached 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. io the Funeral Director; After this certificate has been signed of completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death. Funeral Director: After this 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

3 2010

32. Registrar's Signature

HEGH-ED 5755 CELARLANE,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death () Month Year **Physician** 2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner none The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day. 7. Age (In yrs. last birthday) **Funeral** onth, Day, Year) Jun 27, 1921 Days Hours Min 026-16-1955 89 Mass **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Columbia MD Howard 1 Yes 2 No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 8990 Old Montgomery Rd. 21045 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No 7/4/1947 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ð 5/31/1974 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Physician / Ret. Army Colonel Healthcare / Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Gustav Fischer Frieda Albertina Brunner မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annalie Burke 8990 Old Montgomery Road Columbia, MD 21045 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dec 15, 2010 Arlington, Virginia **Arlington National Cemetery** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licensee se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disea Approximate shock, or heart failure List only one cause on each line Interval Between Immediate Cause (Final ACUTE DAYS TEAKEWIV **Physician** disease or condition /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ completely filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Tes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 🗌 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending 1 Tes 2 No investigation M 2 Accident 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MO (PHO) Res - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA TIMOTHY F BURNS 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) SEP 13 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Se Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) (301SSAWA) 14:52 PM 2010 Physician ember 11 NOON /Medical 4b. City, Town, or Location of Death . Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Nov. 27, 1933 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Nov. Peru 76 Director 213-34-5033 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Anne Arundel Pasadena Maryland 10g, Citizen of What Country? 10e. Street and Number 10f, Zip-Code 21122 Funeral 7700 Princess Place death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 XMarried 1 XYes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ Peruvian 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Own Home N/A12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Guerrero Dioses Rosa Gregory P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) and l Department of Health a important: If item 27 is any injury or other trau 630 Raven Avenue Gaithersburg, Maryland 20877 Richard Gassaway (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 09/15/2010 Glen Burnie, Maryland Glen Haven Mem. Pk. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena. Maryland 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Met Grian **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 Probably 4 Unknown 1 TYes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 2 No 1 Yes 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be examiner? Other: 4 \sum Nursing Home Hospital: 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA မှ 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 💢 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only

To the Hospital within 24 hours a To the Funeral C

State Registrar

one)

29b. Signature and title of certifier

31. Date file

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

RES-000

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Gress August 31 3:21 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15621 Ancient Oak Drive Gaithersburg Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F (Month, Day, Year) c. 28, 1922 Months Days Hours Min. 507-64-6474 87 Director Gresham, NE Dec. Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland at Hygiene do dother than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Nebraska **Boone** Albian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 68620 3253 240th Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carl Keehn Anna Geisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15621 Ancient Oak Drive, Gaithersburg, MD 20878 Ron Gress (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 2 Cremation 3 Removal from State 9-10-2010 Evergreen Cemetery 4 Donatio 5 Other (Specify) St. Edward, NE Signature of Huneral Service License 22 Name and Address of Facility Miller-Levander Funeral Home, Inc. Lun 308 W. Marengo St., Albion, NE 68620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pancreatic Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth
Pregnant
Unknown in the past 12 months?
1 ☐ Yes 2 ☒ No Day Year Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: Son's
4 Nursing Home 5 Residence 6 M Other (Steel # 1 dence မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse rectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D62234 September 2, 2010

State Registrar DHMH 17 Rev 7/2009

ORIGINAL

9707 Medical Center Dr. Suite300 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manish Agrawal, M.D.

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 28572 State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) September 6, 2010 Physician/ 5:20 P M Gardner Kathryn Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Kensington Kensington Park Retirement If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Country) Iowa **Funeral** (Month, Day, Year) April 15, Months Days Hours 1 □ M 2 🔯 1920 Director 015-05-6406 90 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 1 Yes 21 No Kensington MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 3618 Littledale Road 20895 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2🏗 No If Yes Give Specify. Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Elementary Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Helen Adkins Paul Burroughs Bartlett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1415 Highland Drive, Silver Spring, MD 20910 Carol Gardner/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place)
Bailey Island
Cemetery Buriel 2 Cremation 3 Removal from State 09-18-2010 Bailey Island, ME 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Brackett Funeral Home 21. Sign ture of Juneral Service Licen e 29 Federal me Brunswick Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Makin son Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con uence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician men ha Physician/Medical Records, P.O. Box 68760 use as 1 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancyOther (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 5 signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 🖾 Residence 6 🗆 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes မ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 2 🗆 No within 24 hours after death.

To the Funeral Director: A completed filled in by the form 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 29c. License number

State Registrar 30. Name and address of person who cor

12600114

eted cause of death (Item 23a) (Type, Print)

Registrar's Signa

Durer

Type, Print) DOUG BIVE SUJE # 110 ROCKVILLE,

2010.

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mo.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Titm 30 per dvr g907 9-13-10 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N& U Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1300 Rac Ann Heuber 03 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia, HOWARD CourT Maryland Gereral HOWAYD Itospiral If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Sex **Funeral** Months Days 1 □ M 2 F PA 55 210.36.7422 May 18, 1955 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Mudical Examine to national at Columbia 1 ☐ Yes 2 No MD Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21045 8706 Warm Waves Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ne If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2/□No Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **Health Services** Health Care Co-ordinator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Cipcic Raymond Kuzminski ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8706 Warm Waves Way Columbia, MD 21045 **Edward T. Heubert spouse** Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD Sep 13, 2010 Atlantic Crematory, LLC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Flunera Service Lie Approximate Interval Between Onset and Death 23a. Part 1. Enter the Aisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final carcinona Metastatic Small **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnent at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2 ☑No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 prounotherax 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 €1No 2 ☐ No 1 ☐ Yes teremic 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 2010 00066511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Charter Dr. #310 Columbia, Md. 21044 Nishi Rawat 32. Red 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 28574 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 9 Physician/ 2010 Jean Fessler Hannan 9:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 111 Hamlet Hill Road <u>Baltimore</u> If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Months Hours  $0ct^{(Month, Day)}$ Maryland Director 215-28-7270 82 Usual Residence of Decedent f show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 Hamlet Hill Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Α. Fessler Carolyn Humphries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven R. Hannan 20th Street (son) Atlantic Beach. FL20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 9-13-10 Pikesville, Maryland 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final om Mications tracture Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 EXAMINER attending physician for use as the buria Physician/Medical Box 68760 CENTRICATION APPROVED BY IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Records, P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown been signature should b 1 Tes Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy performed Yes 2 certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 🗚 No 5 Pending ithin 24 hours after death.

the Funeral Director: A completed filled in by the fu 26/2010 Fall Investigation un Knowu M 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) Baltimore Home Hom let 111 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Samara, Warel 52018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore rd 200 East State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 4 \_ Month Physician/ 10:20 D.M 2010 Jackson Catherine Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** agnes Health Saltimore N/A Care If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 □ M 2 🗓 F 16775571921 Maryland 88 220-24-5698 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No N/A Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 2516 W. Fairmount Ave. 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 ☐ Divorced Black Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Reads Drug Store 12th Grade Waitress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Pearl Wyatt Rev. George W. Brown 19a. Informant's Name/Relationship (Type, Print) child) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 Flintshire Rd. Apt 203, Balto., MD 21237 Veronica Taylor-Green 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Jenstery Trematory or other plant Crematory <sup>ла</sup>F<sup>\*)</sup>/Н 09/11/10 1 Burial 2 Carcemation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22.</sup> Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 2140 N Fulton Ave.,Baltimore,MD 21217 21. Signature of Fuur al Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final infarction Physician/ MUDCArdin disease or condition resulting in death) nknina Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown ed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I ò 1 🗌 Yes 2 🗋 No 3 🗍 Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? 1 Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 FR/Outpatient 3 IDOA this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral pirector of the funeral completed filled in by the function filled filled in by the funeral completed filled in by the funeral completed filled in by the funeral completed filled 1 Matural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number D47353 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore 5. Cartun wick, m 900 KNIK Jun 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11.27 8 Donald Warren Jacobs Jr. 2010 Medical County of Death Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death BALTIMORE DAKINGTON GLEN Drust 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Months Hours Min 0470171949 Maryland 61 219 50 4108 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie Maryland Anne Arundel 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 1759 Marley Avenue 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 A Married 1 ☐ Yes 2 A No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) be filed within Mental Hygiene. Shipping Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald W. Jacobs Sr. Florence Price Page 1 and 2 should Important: If item 27 is many injury or other \*\*\*\* and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Jacobs / Wife 1759 Marley Avenue Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 09/09/2010 Baltimore, Maryland 5 Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A 21. Signature of E neral Service Baltimore, Maryland 21225 Ritchie Highway 4001 Enter the disease, or complications that caused tile death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner V Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury romil Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) the detached 9 Unknown יי שוס runeral ulrector. After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No မှ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury death. 2 🗌 No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type Print) 11/ 301 Hos Ochal

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28577 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/2010 Mary Kordonski АМ 6:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11130 Philadelphia Rd. White Marsh Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F 09/28/1916 214-05-3624 Director 93 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10h Counts within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore White Marsh 1 Tes 2 K No 10e Street and Number 6 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 11130 Philadelphia Rd. 21162 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 H No Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Home Maker Own\_Home permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Paul Debole Maria Spivero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Verleger Daughter 9602 Amberleigh Lane Unit N Baltimore, MD 21128 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 09/13/2010 **Dundalk** 4 ☐ Dongtion 5 ☐ Other (Specify) . Signature f Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. Belair Rd Nottingham, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Pancreatic Cancer Medical ue to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burlal-transit ause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Day Month Year 9 Unknown 9 Unknown sate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chimic rend insufficient 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? De man ha 24a. Was an After this certificate has performed? Yes 2 No ASCUM 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ြု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after deam ral Director; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D 31295 9/11/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beech

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Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Kordonski , Sr. 9:30 P M Physician/ Gerard Michael Sept 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dunda1k Baltimore Co. 3424 Dunhaven Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 X M 2 ☐ F Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) 220-20-2305 82 Director 20.1928 June Maryland Usual Residence of Decedent show 10d, Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3424 Dunhaven Road 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2x No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 ₭ Widowed 4 □ Divorced Year or Dates al Hygiene. cother than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other the any injury or other traumatic event, the 1 once. Machinist Steel Industry 12 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Helen Wisniewski Michael S. Kordonski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 19a. Informant's Name/Relationship (Type, Print) Parkwood, Maryland Mrs. Linda C. Soth (Daughter) 2804 Linwood Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Sacred Ht. of Jesus Cem. 9/13/2010 Dundalk, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failed. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Non-Hodgkin Physician/ disease or condition resulting in death) Lymshome Medical Due to (or as a consequence of): Examiner ull - Small Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2: autopsy performed? death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 1 Nes 2 No death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Madelaine Benner DNP, CRNP R176874 09109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Bayview Circle, Bultimore, MD 21224 BINNER CRNP MADELAINE 37 Registrar's Signature

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State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of	Marylan		rtment of		and Men	tal Hygi	ene 201	10	28579
			Registrar  1. Decedent's Name (First, Middle,	l ast)		Cen	tificate of	Death	2.0	Re Date of Death	g. Ital	0	3. Time of Death
	ysicia Medic	al .	JOANN	KIDW	ELL				SE	PTEMB	ER 8 2	Year 2010	1:04 PM
E	xamin	er	4a. Facility Name (if not institution, s			PICALCENIA	4b. City, Town, o		of Death	5	4c. County		
	neral ector	0)			7. Age (In yrs. I		If Under 1 Year Months Days	If Under Hours		Date of Birth Month, Day 28	Year) 942	9. Birthp Coun Mar	olace (State or Foreign try) Vland
*			Usual Residence of Decedent  10a, State 10b, County			y, Town or Loc	ation						0d. Inside City Limits
arylan	a-f sh ified a	Director		Baltimore	100.01	y, lowir or Loc	alion	Dund	a1k			ľ	1 ☐ Yes 2 ☑ No
the M	a or 28 be not	흡	10e. Street and Number	Dareimore			10f. Zip Code			10	0g. Citizen of V		,
ath with	ms 23	Funeral	1819 Kinship Ro	12. Was Dece	tent Ever in U.	S 13 W	/as Decedent of I	21222		es or No-	United		an Indian,
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	É	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Armed For	ces? 2 X No		/as Decedent of H Yes, specify Cub ☐ Yes 2X No		n, etc.)		k, White,			
	Completed	15. Decedent (Specify only highes			[ (Give k	ent's Usual Occu ind of work done	during most	t of working		16b. Kind of Bu	usiness Ind	dustry	
within giene.	er thar , the M	Con	Elementary/Seconday (0-12) 8 Years	College (1-	4 or 5+)	1	NOT use retired Homemake				Own	Home	<u> </u>
land 2 be filed wit lental Hygie	ed oth event	To Be	17. Father's Name (First, Middle, La	st)				l .	er's Name <i>(Fir</i> s		aiden Surname	<del>)</del> )	
Maryland 2 should be filed th and Mental Hy	s mark umatic		Thomas F. Ash  19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street	and Numbe	er or Rural Rou	ite Number. (	City or Town, S	tate, Zip C	Code)
e, Mand 2 s	em 27 i ther tra		Beverly Egan  20a. Method of Disposition	(Cousin)	205 [		Gates Wo	od Ro					.093
Baltimore, permit. Page 1 and Department of Hea	ant: If ite ury or of		1 [X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	cemetery, crem	sition (Name of latory or other pla Cemetery		9/13/20		20c. Location - Balti	-	, Maryland
Balt permit. Depart	Import any inj once.		21. Signature of fundal Service Lie	ensee	)	<sup>2</sup> 2	Name and Addr uda-Ruck 7922 Wis	ess of Facilit Fune e Ave	eral Hor Dunc	me of	Dundal Marylar	k, Ir nd_2	nc. 21222
			23a. Part . Enter the disease, or of shock, or heart failure. List or	ly one cause on each	:h line.						st,		Approximate Interval Between Onset and Death
Physi Me	ician edical	9 7	Immediate Cause (Final disease or condition resulting in death)	a. PUS	ELESS :	ELECT	ZICAL A	CTIVIT	y AKR	EST		- 2	
Exa	miner	Ļ	Sequentially list conditions, if any leading to immediate  b. Due to (or as a consequence of):									2	25 minutes
pe	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (	or as a conseq							- 1	
e execu	sian and urial-tra	al Exa	that initiated events resulting in death) Last	Due to (	or as a conseq	uence of):							
760	g pnysic	ledical		d									
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	the attending hed for use a	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Birth 2 D Feta nant at time of	al death 3 🗌	Ectopic pregnar Other (specify)	псу				te of deliventh	ery Day Year
S, P.O.	n signed by Id be detac	d by Ph	Part II. Other significant condition	as contributing to de	eath but not res		nderlying cause g		l.	23e. Did tob			he cause of death?
Division of Vital Records, all or Attending Physician: The law requires after death.	e has beel age 2 shou	omplet								24a. Was an autops perform	y ned?		psy findings available impletion of cause of
tal F	ertifical ector, p	Be C	25. Was case referred to medical examiner?	Hospital:	/		-		ath (Check only		LIE NO	103	
of VI	er this ceral dire	e: To	1 ☐ Yes 2 M No 27. Manner of Death	28a. Date	npatient 2 _ of injury	28b. Time of	28c. Inju	ry at			nce 6 Othe		/)
ION ( tending leath.	or: Afte	Certificate:	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could n	ation	h, Day, Year)	injury		Yes 2			-		
Divis al or At s after c	al Direct		4 Homicide determin	28e. Place	of Injury - At he ng, etc. <i>(Specif</i>		et, factory, office			Location (Str City or Town,		er or Rura	l Route Number,
ne Hospit n 24 hour	pleted fills	Medical	(Check 2 Medical Ex	Physician: To the beaminer: On the bas Nurse Practioner:	s of examination	n and/or invest	igation, in my opin	ion, death o	ccurred at the ti	ime, date and	d place, and due	e to the ca	use(s) and manner stated.
To th	ro ti		29b. Signature and title of certifier	a Pin	1200		29c. Licen:	Se number	00		gd. Date signed		Day, Year)
			30. Name and address of person w	A .T	e of death (Iter	n 23a) (Type, P					1D	212	24
R	Stat egistra		31. Date filed (Month, Day, Year) SEP 1320		egistrar's Signa		w						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State Registrar	State of Ma	•	artment of Health <i>tificate of Death</i>	n and Mental Hyg	giene Reg. N2010	28580				
1. Decedent's Name (First, Mid Physician/ Miami Virginia	. ,			2. Date of Dea Month Septemb	Day Year	3. Time of Death 0 5:30 P M				
Medical Examiner  4a. Facility Name (if not institut			4b. City, Town, or Location		4c. County of Dea	th				
907 Boundbrook  5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)		er 24 Hrs. 8. Date of Birt Min. (Month, Day	h 9. Bir	thplace (State or Foreign				
Director 217 26 6623 Usual Residence of Decedent	T C W Z A	80 Yrs.		Min. (Month, Day Feb. 21,	1930   Ma	ryland				
Maryland Balti	· .	10c. City, Town or Loc	ssex			10d. Inside City Limits 1 ☐ Yes 2 🔀 No				
the Mark Top and Top a	-		10f. Zip Code		•	Citizen of What Country?				
graph with the state of the sta	12. Was Decedent E		21221 Was Decedent of Hispanic C		USA 14. Race - Ame	erican Indian,				
P 29	If Voc Cive	No	f Yes, specify Cuban, Mexic		Black, Whit	•				
15. Decressed in the matural of the	dent's Education ghest grade completed)	(Give I	lent's Usual Occupation kind of work done during mo O NOT use retired)	ost of working	16b. Kind of Business					
D be A Hydron or D be A		Own	er/Operator	N. S. M (***)	House Clea	ning				
Personal Part of the part of t	e, Lastj		I .	ther's Name (First, Middle, rdella Hopki)	·					
Agy Midowed 4 □ Divorce 15. Dece (Specify only high Elementary/Seconday (0-12 8			ng Address (Street and Num Gunder Avenue							
20a. Method of Disposition	on 3 Removal from State	20b. Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - City or					
20a. Method of Disposition  1   XBurial 2   Cremati  2   Donation 5   Othe  21. Si rai re() Funeral Service	r (Specify)		eterans Cemet		∪ Mary	land				
1 JOTUN IV.	Kurkows	2 1	Name and Address of Fac ruzdzinski Fi 407 Old Faste	<u>ern Avenue E</u>	ssex, Maryl	and 21221				
Immediate Cause (Final	or complications that caused at only one cause on each line	·A _ A	er the mode of dying, such a		est,	Approximate Interval Between Onset and Death				
Medical resulting in death)  Examiner	disease or condition resulting in death)  a. Due to (or as a consequence of):									
Coquentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):								
Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):								
ate be executed the physician and the burial transition and the burial	d									
Jif FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy	*	23d. Date of de					
The death certificate by the detail certificate by the attending plysic and by the death certificate by the d	4 ☐ Pregnant a 9 ☐ Unknown		Other (specify)		Month Day Year					
ords, P.O. Box 683  requires that the death certific the death certific should be detached by the attending should be detached for use as a found by the attending a found by the attending should be detached for use as a found by the attending should be detached for use as a found by the attending should be detached b	itions contributing to death b	ut not resulting in the u	nderlying cause given in Pa	23e. Did to	obacco use contribute t Yes 2 ∰No 3 □ F	o the cause of death? Probably 4 🗆 Unknown				
Division of Vital Records,  tal or Attending Physician: The law requires a Brector: After this certificate has been signed in by the funeral director, page 2 should be din by the funeral director, page 2 should be conficient by the funeral director, page 2 should be conficient by the funeral director, page 2 should be conficient by the funeral director, page 2 should be conficient and conficient by the funeral director and conficient by the function of the function of the funeral director and conficient by the function of t				24a. Was autop		utopsy findings available completion of cause of				
B 25. Was case referred to medic examiner?	al		26. Place of De	1 ☐ Yes eath (Check only one)		es 2 No				
P 27. Manner of Death	Hospital:  1  Inpatie  28a. Date of inju	ent 2 ER/Outpatier		Nursing Home 5 X Resid	dence 6 Other (Spe	cify)				
or Attending B of Att	ding (Month, Day stigation		work?  M 1  Yes 2	_	ow injury occurred					
Olytisal or Afte all or Afte a	28e. Place of Injubulding, etc	rry - At home, farm, str :. (Specify)	eet, factory, office	28f. Location (S City or Tow	Street and Number or Runn, State)	ural Route Number,				
29a. Certifier 1 Certify (Check 2 Medical	ing Physician: To the best of al Examiner: On the basis of ex ing Nurse Practioner: To the	kamination and/or inves	tigation, in my opinion, death	occurred at the time, date a	nd place, and due to the	cause(s) and manner stated.				
29b. Signature and title of certification	Sauchy	, MO	29c. License number MD 006 7		29d. Date signed (Mont					
30. Name and address of pers	on who completed cause of divided of the NCHEL - CHESP	eath (Item 23a) (Type, F	Print) DY BASTERN	BIVO ESSE	K, MD 21	221				
State Registrar	2010 82. Registra	r's Signature	Ke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9 0755AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 1 🗆 M 2 🕅 F Days Min. (Month, Day, 194<u>5</u> Mary Land Months Hours Nov. Director 214-44-3686 64 Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 West Conway Street 21201 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 14. Race - American Indian. 11, Marital Status Black, White, etc. <u>გ</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates Completed 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stonewall Thompson Marv Louise Sunderland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 8277 Bodkin Avenue Pasadena, Wendy L. Bowman (Daughter) Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 09/13/2010 4 Donation 5 Other (Specify) Brooklyn Park, Maryland Name and Address of Facility CCully-Polyniak Funeral Home, P.A. 204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter lock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical De to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence ci): ending physician and use as the burial-transit **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 month 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown n signed by the a ld be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I autopsy **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes ٥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29c. License number 23a) (Type, Print) of person who completed cause o 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 3 12:15 AM 2/10 **Physician** Lisa Marie Linsenmeyer /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/17/1964 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2**X** F 46 Maryland 219 90 7667 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exprisive must be routhed at 1 ☐ Yes 2 ☐XNo Glen Burnie Anne Arundel Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21060 904 Silver Maple Court death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🛛 No Specify: Specify: à White 3 ☐ Widowed 4 No Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) be filed within Elementary/Secondary (0-12) 12th n and Mental Hygiene. College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be George W. Linsenmyer Jr. Jo Anne Fico ျှ and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 904 Silver Maple Court Glen Burnie, Maryland 21060 Health a Jo Anne Linsenmeyer / Mother Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 o ... 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō permit. Page Department o Important: If any Injury or once. Baltimore, Maryland 09/04/2010 | 4 □ Donation 5 □ Other (Specify) Bavview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metast **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality for as a nonsequence of: Examiner The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? for 4 ☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 ☐ Unknown 9 Unknown þ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 2 No 1 □Yes or Attending Physician: : After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manuer of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only 29d. Datessigned (Month, Day, Year) Sevender 3, 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 H USpital Drive George E. Wicks Dt M.D. Glen Burnis, MD

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month

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Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene	2010	28583
Certificate of Death		

		1- For State Registrar		Certific	ate of	Death			Re	eg. No.			
Physicia	ın/	1. Decedent's Name (First, Mic							Date of Deal Month	Day	Year	3. Time of Death	
Medical Exami	ner	James Boyd N			Та	b Oit Tour			Septembe			1700 hrs	
,		4a. Facility Name (if not institu 7914 Bradshaw Roa				b. City, Town, o Kingsville	_Uppe:	r Fal	1s		County of Death  Iltimore Cou	nty	
Funeral Director		5. Social Security Number		(In yrs. last bir	thday)	If Under 1 Ye	ear If Unde	$\overline{}$			D/YYYY) 9. Birt Foreig		
Director		419-58-5834	1 M 2 F	67	Yrs.				Januar	y 14	,1943 Coi	Rome, Georgia	
à		Usual Residence of Decedent 10a. State 10b. Count	ty 1	Oc. City, Town	or Location	on						10d. Inside City Limits	
P 20 48		Md. I	Balto.	Unne	er Fa	119						1 Yes 2 No	
arylan 8a-f s	g	10e. Street and Number	ALCO:	СРР		10f. Zip Code			10	Og. Citize	en of What Cour	try?	
the Market a or 2	Director	7914 Bradsha	w Road			2	1156				USA		
with us 23s	ra	11. Marital Status	12. Was Decedent E	ver in U.S.		Decedent of F	lispanic Orig			- 1	4. Race - Americ	can Indian, Black,	
death or ite	Funeral	1 Never Married 2 X	1 X Yes 2	No	II Ye	s, specify Cub	an, mexican	, Puerto Rio	can, etc.)		White, etc.	T71- 4	
s after ral",	2		Divorced If Yes, Give Year or Dates:	List Date			lo specify:				pecify:	White	
hour "natu	ted	Elementary/Secondary (0-1)	pecify only highest grade complex.  College (1-4 or 5+			s Usual Occup st of working lit				16b. Kir	nd of Business/Ir	ndustry	
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5-00 ed wij Tygier other	히	17. Father's Name (First, Midd	le, Last)				1B.Mother	's Name (Fi	irst, Middle, N	faiden S	urname)	OHIOH	
121   be fill ental F   rrked	å	Ottis McHugh							Lancas				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	유	19a. Informant's Name/Relatio									or Town, State,		
and 2 and 2 ealth cen 2 traum	1	Danielle G. N  20a. Method of Disposition	AcHugh Spot		7914 of Disposit	ion (Name of c	emetery.		per Fa	111s 20c. Lo	Md. 2	L L 56 Fown, State	
Ore ges 1 t of H t If ii	- 1	1 X Burial 2 Cremati	on 3 Removal from State		tory or oth						,		
Itim it. Pa rumen ortant y or c	H	4 Donation 5 Other 21. Signature of Funeral Service		Park	Wood	Cemete	rv es of Facility	9-11 <b>-</b>	2010	Park	ville.	Md.	
Ba perm Depa Imp	Ų	Shannon (	Dogwore		97	05 Bela	ir Rd	Schim No	unek ttingh	Fune	ral How id. 2123	6	
Physician	7		or complications that caused th	e death. Do n	ot enter the	mode of dying	g, such as c	ardiac or re	spiratory arre	st, shock	k, or heart	Approximate interval	
/Medical Examiner	-	Immediate Cause (Final disease	01 1 1 11 11	of Chest								Between Onset and Death	
LAMITME	-	or condition resulting in death)	Due to (or as a consequ	uence of):									
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence ofl:	_								
	/Medical Examine	cause. Enter Underlying Cause (tributed average resulting indicating least a consequence of):  Due to (or as a consequence of):								_			
ed	Exa	events resulting in death) Last		uence of):									
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60, ate be hysicia e buria	led led	IF FEMALE:	#4b8		rME,	907 <b>,</b> 9/	28/20	10,WS		23d.	Date of delivery		
		23b. Was decedent pregnant in past 12 months?	the 1 Live birth	2	E Feta	death 3	Ectopic	pregnancy	•		onth D	ay Year	
Box 687  death certific  the attending of the ast	Physician	1 Yes 2 No 9 U	4 Pregnant at tin	ne of death	5 Oth	er (Specify)							
O. B trthe d by the	튑	Part II. Other significant cond	ditions contributing to death b	out not resulting	g in the un	derlying cause	given in Pa	rt I.	23e. Did tol	bacco us	e contribute to t	ne cause of death?	
, P.O. res that the signed by be detach	2								1 Yes	21	No 3 Proba	ably 4 🗸 Unknown	
of Vital Records, ng Physician: The law require ther this certificate has been si nneral director, page 2 should b	Completed								24a. Was a			opsy findings available	
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tal Rec		25. Was case referred to medic	cal		_	26.Plac	e of Death (	Check only		No No	1 🗸 Yes	3 2 No	
Vita	To Be	examiner?	Hospital: 1 Inpatient	2 ER/0	utpatient	3 DOA	Other <sub>4</sub>	Nursing H	ome 5 I	Residenc	e 6 🗸 Other:	Scene	
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ttend death. ctor:	[랿		nding estigation Sep 7, 2010		IND: 3 hrs	1	Yes 2 ✓	No	·				
Division spital or Attenditions after death.	Certification:		uld not be 28e. Place of Injur			factory, office	building, etc		or Town, St	ate)	L L	PhRoute Number, City	
Divis Hospital or A 24 hours after Funeral Dire		29a Cartifier	( Single								, <del>-Kingsville,</del> M		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only   Certifying	Physician: To the best of my k aminer: On the basis of examination and manner stated.										
H % H %	8	29b. Signature and title of certif				29c. Licen				29d. Da	te signed (Mon	th, Day, Year)	
		Canal	2 Halla	~		O.C	.M.E.			Septe	mber 8, 201	0	
101			on who completed cause of dear ssistant Medical Examir		Penn St	reet, Baltim	nore, MD	21201					
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DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Casper J. Marcovitch Settember 8, Day 2010 Physician/ 4:50 a M Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles Charlotte Hall Charlotte Hall VA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea May 11, 191 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Country) Pennsylvania 1 XM 2 - F 169-03-5222 93 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director or 28a-f s notified MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 21230 U.S.A. 2559 Marbourne Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status med Forces? XYes 2 □ NoWW∏ ģ 1 Never Married 2 Married XYes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Giver Year or Dakorea Vietnam Specify: white 3 XWidowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Army U.S. Army 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Antonia Burba Joseph Marcovitch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3911 Washington Street Baltimore, Maryland 21230 Charles Chaney nephew 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Park Sept 11, 2010 Elkridge , Maryland 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home, P.A, 21. Signature of Fer 237 Fast Patapsco Avenue Baltimore, MD 21225 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Enter the disease Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit TAD Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Year Month Pregnant at time of death 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 🖺 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

lot 1

DHMH 17 Rev 7/2009

State Registrar HALL

29449 CHARLOTTE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCISCA

31. Date filed (Month, Day, Year) SEP 13 2010

D67814

CHARLOTTE

9/8/10

HALL

Box 68760, P.O. of Vital Records, Division

Director; within 24 hours a

Registrar

DHMH 17 Rev 1/2001

Medical

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL AVENUE
14. ROBERT BIRSCHBACH
CAITHERS BURE, MD 20877

V. Robert Birschhack wist.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

04115

September 6,2010

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		-	For State		State	of Marylar	•	artment <i>tificate</i>			ınd M	ental Hy	giene			
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Д	Medic Examin	al .	4a. Facility Name (if					4b. City, T	Town, or Lo	ocation of	Death			ounty of Dea		
			Gilcres	t				Ba	ltim	ore			N	/A		
	Funeral		<ol><li>Social Security N</li></ol>	lumber	6. Sex 1  M 2  XF	7. Age (In yrs.	ast birthday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.					8. Date of Bir		rthplace (State	or Foreign	
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	with t	eral	300 Can	tata (	Court				2113	6			U.S	. A .		
	eath v	Funeral Director	11. Marital Status	00.00	12. Was Dec	cedent Ever in U.	.S. 13.		<u>-</u>		in? (Spec	cify Yes or No- Rican, etc.)		4. Race - Am	erican Indian,	
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8	urs a tural" al Exa	te e	3 X Widowed		Year or D	Dates.	1 ☐ Yes 2 ĀNo Specify:							pecify: Bl	_	
5-(	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed	(Spe	15. Decede ecify only high	nt's Education est grade completed	al)	I (Give	dent's Usual kind of work O NOT use	k done duri	on ring most	of workin	g	16b. Kin	d of Business	s Industry	2
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<u>la</u> n	be fi lental rked ic ev	요	Richard Reynolds							Mary	Į.					
ary	2 should be filed within 72 th and Mental Hygiene. ?7 is marked other than " traumatic event, the Mec		19a. Informant's N	ame/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street and	d Number	or Rural	Route Numbe	r, City or To	own, State, Z	ip Code)	
Σ	nd 2 sealth an 27 i		Leo Mim	s(son	)		1215	Pal	ladi	an V	√ay,	Frede				
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Baltimore, Maryland 21215-0036	: Pag tment tant: jury c		4 Donation	5 Other (	Specify)	Añ	Sephre Vd Cre					1/10		timor		
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	ineral Service	Licensee	Wille	1/1/20 2	්ර්ර්ජ් 140 1	bh <sup>re</sup> n N Fu	itor	rown 1 Av	Jr. e.,Ba	Fune ltim	ral H ore,M	ome PA	17
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	or Attending Physician: The law requires that the death certificate be executed ter death.  for death.  irector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	Sequentially list or leave and the cause. Enter Unde Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was decedent in the past 12' 1	t pregnant trenths?  It pregnant trenths?  I	Due to b	o (or as a consective or as a consective or as a consective or or as a consective or as a	quence of):  quenc	Ectopic p Other (spe underlying c  nt 3 DC f 28 M reet, factory,	26. Place 26. Place 27. Other: 28. Injury a work? 1  Yes, office	e of Deat  4  Nu  at  es 2   date and p death oc	h (Check rsing Hor 2 No	24a. Was auto perfet 1 — Yes only one)  me 5 — Resi 28d. Describe 1 — City or Tot didue to the cathe time, date	obacco us Yes 2 [ an psy ormed? 2 No dence 6 [ now injury street and wn, State) ause(s) and and place, a	Month  e contribute  No 3   24b. Were a prior to death? 1  Ye  Other (Specocurred  Number or Famous as and due to the and manner as	elivery Day  to the cause of Probably 4  utopsy findings completion of ess 2 \( \text{No} \)  variated. e cause(s) and m is stated.	Year  death?  Unknown s available cause of
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9 0 2010 mishe 20110S /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1**⊠** M 2□ F 69 Sept.7,1941 Director Pennsylvania 220 38 5716 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show at 1 ☐ Yes 2 No 28a-f sh notified Maryland Baltimore Essex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 1910 Sue Creek Drive 21221 USA death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 XYes 2 No If Yes, Give 1958/59 Year or Dates! 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 2 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) College (1-4or 5+) it of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Shipping Long Shoreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julius Misher Theresa Redd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thea Jo Misher (Wife) 1910 Sue Creek Drive Baltimore, Maryland\_21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Department o Important: If any Injury or once. 4 Donation 5 Other (Specify) Dulaney Valley Mem. Gardens 9/13/20/10 Timonium, Maryland 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 0 ohn 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac are /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any learning learning learning cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) • Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 2□ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical Nurse Practioner and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier R106262 September 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Ward CRNP 5505 Hopkins Bayview Circle Baltimore, Maryland 21224 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28588 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:29 A<sup>M</sup> Fannie Myrtle Myers September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Carroll Hospice Dove House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year July 5, 1 1 🗆 M 2 🖾 F Months Days Hours Min. Director 214-01-0654 1916 Pennsylvania Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 179 Willis St. 21157 within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1  $\square$  Never Married 2  $\square$  Married Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Deanie Flohr Robert E. Gonder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra 179 Willis St. Joyce E. Myers/ daughter Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Meadow Branch Cem. 9/13/2010 Westminster, MD Syn ir, o Funeral Service Lie 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Owet and Death Immediate Cause (Final Due to (on) a consequence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury que italiv list conditions. Examine Due to (or as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 As Day Pregnant at time of death the 9 Unknown 9 Unknown P.O. ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown been signature 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 Yes 2 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ပ 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowle occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed of

SEP 1 3 2010

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:28 Рм Irene Annie Michael 2010 September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hart Heritage Estates Forest Hill Harford 5. Social Security Number 8. Date of Birth (Month, Day, April 2 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗓 F Min. Director 216-09-6921 96 Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2x No Maryland Fallston Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2104 Lippizan CT. 21047 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas James Cunningham Laura Knoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2104 Lippizan Ct.</u> <u>Nancy Debelius / Daughter</u> Fallston, MD 21047-1627 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 9/10/2010 Brooklyn, Maryland 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home,
421 Crain Hwy. SE; Glen Burn of Funyral Se y cl 21061 23a. Part 1: Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FIND Physician/ STAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be lirector, page 2 s autopsy performed' Yes 2 No 25. Was case referred to medical OSS, Sted Be 26. Place of Death (Check only one) examiner? 1 Yes Other: CARL Certificate: To 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural
Accident
Suicide
Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. MAR PHAIL 615 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 09 Physician/ 2010 5:08p Patterson Darlene Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/ABaltimore Gilcrest 8. Date of Birth g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Funeral Days Hours Mary land 1 ☐ M 2 F 06/18/1967 Months 43 Yrs Director 219-02-2915 Usual Residence of Decedent or 28a-f show notified at: 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 X Yes 2 No Baltimore N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō the Medical Examiner must be by Funeral 23a 21239 1419 Walker Ave. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. within 72 hours after death Black, White, etc. Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. 12th Grade College (1-4 or 5+) Secretary City Jail event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F 27 is marked of traumatic even ည permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked Ozora Miles Donald L. Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1419 Walker Ave., Baltimore, MD 21239 Ozora Patterson(mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 09/11/10 Baltimore, MD Park 4 Donatton 5 Other (Specify) Kina Mem. Joseph H. Brown Jr. Funeral Home PA 2140 N Fulton Ave., Baltimore, MD 21217 21. Signature of Furieral Service License any ir 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 47515 Physician/ disease or condition Medical resulting in death) Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FFMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Day Year in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 Unknown g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy completed filled in by the funeral director, page 2 performed? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA |은 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Medical Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending M Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and tille of certifier 29c. License number 29b. Signatur Atember 6 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) works 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 3 2010 Registrar

'n

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		Cen	tificate of D		R	eg. N2 0 1 0	28591
	Physicia		1. Decedent's Name (First, Middle, Las George J	Pruchniew	oski		-	2. Date of Deat Month September	Dav Year	3. Time of Death <b>07: 97 A</b> M
	Medic Examin		4a. Facility Name (if not institution, give	street and number)			Location of Death	1	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sec 217–16–7586	NYVIEW ME © M 2 □ F 87	In yrs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 22	9 Bi	rthplace (State or Foreign ountry) aryland
	/land f show ed at	tor	Usual Residence of Decedent  10a. State  10b. County	1	I Oc. City, Town or Loc	ation				10d. Inside City Limits
	ne Mary or 28a- notifie	Director	MD Balt  10e. Street and Number	imore		Dun	da1k		0g. Citizen of What C	1 Yes XX No
	s 23a c	Funeral	2610 Lynbrook Ro	ad			21 22		United	·
030	e filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 12 Yes 2 No If Yes, Give Year or Dates.	o If	/as Decedent of Hi Yes, specify Cuba Yes 2 Mo	n, Mexican, Puerto	oecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:	
212-0030	nin 72 hour ne. han "natur e Medical	Completed	15. Decedent's Ec (Specify only highest gra	ducation	(Give ki	ent's Usual Occupa ind of work done d NOT use retired)	luring most of wor	,	16b. Kind of Business	
	filed with al Hygier <b>d other t</b> went, th	BeC	G • E • D •  17. Father's Name (First, Middle, Last)		Electr	ic Motor	-	an ne (First, Middle, M		nghouse
yland	should be fill and Mental is marked aumatic ev	မ	Joseph Pruchnie							
Mar	12 shou lith and 27 is r		19a. Informant's Name/Relationship (Ty Mr. George J. Pr		1	g Address (Street a Hallhur		ral Route Number, Baltimoı	City or Town, State, Z	ip Code) 21236
saltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er once.		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	20b. Place of Dispos cemetery, crem				20c. Location - City o	
	mit. Pag bartmen bortant: 'injury 'e.		4 ☐ Dopation 5 ☑ Other (Specify 21. Sign rure of June 1 Service License	<sup>)</sup> Entombmer	Parkwoo 22.	d Cemete:	ry 9/14	4/2010	Baltimor	e. Maryland
ñ	permir Depar Impon any in		Mag 1	11- 0	1	7922 Wis	se Ave.	Dundalk.	Dundalk, Maryland	Inc. 21222
~ F	Physician/ Medical	10 P	23a. Part Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	STROKE WI			_		Approximate Interval Between Onset and Death 36 -48 hoors
	Examiner	L	Sequentially list conditions,	Due to (or as a c	201					710 years
	and transit	Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last	Due to (or as a c	ESTEROLEM	ιA				>10years
00/0	ate be exemple by the purial	dical	resulting in death) cast	d	onsoquence on.					
DOX DO	e death certifica the attending p	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of					23d. Date of de	
		ysic	1 Yes 2 No 9 Unknown	4 Pregnant at til	□ Fetal death 3 □ me of death 5 □	Other (specify)	у		Month	olivery Day Year
, r.	ires that th signed by d be detac		9 Unknown  Part II. Other significant conditions co	4 Pregnant at til 9 Unknown	me of death 5 🗌	Other (specify)		23e. Did tob	Month acco use contribute to	Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Voar **Physician** JACQUELYN MONCURE PEDDICORD PEASE 12:35 PM 2010 September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner EDENWALD RETIREMENT COMMUNITY Baltimore County Lowson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) July 18, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 F 92 Mary land 219-01-4089 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Baltimore County Towson 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code 800 Southerly Road 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be find and Mental H permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked o any injury or other treumatic events. Everett Moore Peddicord Lucie Isabelle Davenport 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia<u>L.</u> Sutula (Daughter) 21 South Morerick Avenue, Catonsville, Maryland 2122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem Grdns9/8/2010 Timonium, Maryland 21. Signatu for Fundal Server Tronspersor MITCHELL-WIEDEFELD FUNERAL HOME. INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stage dementio End **Physician** /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit ding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No. Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 240 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes or Attending Physicien: 25 Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation after death Director: the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funerel ( 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R15 4032 hear CRNP 2010 To. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 800 Southerly Rd MD Scherr 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPT. 4, 201°0 2010 ESTHER CARLOTA ROMERO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
PRINCE GEORGE'S **Examiner** PRINCE GEORGE'S HOSPIATL CHEVERLY CENTE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 0 2Mg/12/89/ 1993 7 73 PANAMA Director 579-64-6999 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S LANDOVER 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 20785 7801 BARLOWE RD #316 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1X Never Married 2 Married ð Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)  $2 \mathrm{Yrs}$ Elementary/Seconday (0-12) BANKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OSBORNE QUARLESS LUCILLE MILLS (Type, Print)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ELEY/DAUGHTER 1919 BROOKS DR., #301 CAPITOL HGTS., MD. 20743 19a. Informant's Name/Relationship (Type, Print) ANTOINETTE 20b. Place of Disposition (Name of cemetery, crematory or other place)
HARMONY MEM. CEM. 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9/17/10 LANDOVER, MD e #Funeral Service Lice 22. Name and Address of Facility CAPITOL MORTUARY 21. Signati 20002 MARYL AVE 23a. Part 1. Enter the disease olications that caused the death. Do not not not be cause on each line. er the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betwe shock, or heart failure. Lis-Immediate Cause (Final Onset and Death Physician/ disease or condition or Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Liue to (or as a cor Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (a) as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic prechancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 1 Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No ည 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 2 Accident 1 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifie 🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tle of certifie 29c. License numbe 29d. Date signed (Month, Day, Year 102 00 ause of death (Item 23a) 30. Name and add ssof person who complet ra 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Sept. 9, 2010 09:304 Edmund F. Sowers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 100 Governors Court, Apt. J Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F 86 Yrs. 216-16-3362 Director Aug 18, 1924 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other then "naturel", or items 23e or 28e-f show traumatic event, the Medical Examinar must be indiffed at Glen Burnie 1 ☐ Yes 2 ▼ No Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 Governors Court, Apt. J 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: If Yes, Give Year or Dates: White þ 3 Widowed 4 Divorced W 2 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carr Lowery Glass Co. Electrician 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edmund Dewey Frederick Sowers Elsie Marie Cline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) Lelia L. Sowers 100 Governors Court, Apt. J, Glen Burnie, Maryland 21061 Department of Health Importent: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Atlantic Crematory, LLC 9/11/2010 Glen Burnie, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Kevin E Ecker any 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INVAKESIA Physician Mille 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of: Examine certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE. nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No nas page 2 autopsy performed? Yes 2 No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 hesidence 6 Other (Specify) 2 No P 1 Tyes 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 1 Natural 28d. Describe how injury occurred After t Certification: Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital within 24 hours a To the Funerel I La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 055506 9/20/2010 west bottome Phylod 2123 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760. Vital Division of death. within 24 hours after deatl To the Funeral Director: filled in by completely

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

4 Homicide

29a. Certifier

determined

Muc ( Herman, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. HERMAN HARBOR HOSPITAL 32. Registrar's Sign

and manner stated

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

3001 S. HANOVER ST, BALTIMORE, MD

SEPTEMBER 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Physician/ 07 Day 20 10 11:25AM Gertrude Gladys Sye Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Future Care 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 0870671924 Maryland 218-20-0985 Director 86 Usual Residence of Decedent 28a-f show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No N/A MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 3021 Oak Hill 21207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces 1 ☐ Never Married 2 🔀 Married ð 2 XNC Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Completed Black Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l th and Mental Hygiene. ?**7 is marked other than "r** Elementary/Seconday (0-12) 8th Grade College (1-4 or 5+) Nurse Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Cole Sr. Gladys Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Sye(Husband) Oak Hill, Baltimore, MD 21207 3021 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
AHSCEBMaBKOWN F/H 20a. Method of Disposition 20c. Location - City or Town, State Mulia 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 09/11/10 Baltimore, MD of Funeral Service Line nue 21. Signatur and Address of Facility
Ph H. Brow
N Fulton own Jr. Funeral Home PA n Ave.,Baltimore,MD 21217 23a. Part 1. Enter the disease, or complications that caused to eath. Do not enter the mode of dying, such as car liac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Ph\_sician/ TSCASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Examin physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown g Unknown P.O. I signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 1 Yes 3 Probably 4 Unknown is certificate has been si director, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 W No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 🗌 No death Accident Investigation **Director:** Suicide
Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after c

To the Funeral Direct
completed filled in by determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Moghth, Day, Year) 2010 D0043375 se of death (Item 33a) (Type, Print) 30. Name and address of person who completed cause KALEN N.

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:52 AM Smith entember 10,2010 Minnie /Medical 4c. County of Death 4b. City. Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Prince Georges Community Hospita annam Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Davs Hours 1 ☐ M 2 🔀 F 33-38-917 L Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Lanham Director Maryland 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 20 706 death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married o, 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify. þ 3 ☑ Widowed 4 ☐ Divorced 'natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. erK U.S. Government permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumests. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Moose Brother Circle Drive George Fort Washington Maryland 20144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Annandale, Virginia Pleasant Valley Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee obert Chinn Funeral Service 26055 Shirlington Read Arlington, Va. 22206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 'ardiac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) ed by the a detached 1 9□Unknown 9 ☐ Unknown signed by t. d be detach 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 nsion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Maunknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? 1 ☐ Yes 2□ No bri ation 2 X No Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Registrar SEP 1 3 2010

30. Name and address of person who co-

31. Date filed (Month, Day, Year)

732. Registrar's Signature

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Monte **Physician** (8) 40 M vover Ve 2010 /Medical 4a. Facility Name (I not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death **Examiner** ltrurove Johns Hopkins Bayview Care Center N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🙀 F West Virginia September 4, 236-32-5396 86 1924 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and the traumatic event, the Medical Examination and the continual of the continu Director 1√Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4616Walther Boulevard 21214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 XNo Specify: If Yes, Give Year or Dates: <u>≽</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Worker US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira RennisShaver Maude Lee Bolyard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nevagene Shaver/Sister 21214 4616 Walther Avenue Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sunset Mem. Gardens 9/16/10 Kingswood W. Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 5305 HarfordRoad Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as sonsequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.O. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No e Hospital or Attending Physician: The 24 hours after death.
2 Funeral Director; After this certificate hielely filled in by the funeral director, page 1 ☐Yes 2 ☐ No Division of Vital 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2043 83 September 13,2010

Registrar

/ DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. 3. Greenough In M.

32. Registrar's Signature

31. Date filed (Month, Day, Year) SEP 1 3 2010

5505 Hopkins Bay view Cirele Baltimore HO 2/224

	B	De De
•		Phys /Mo Exa
	ox 68760,	h certificate be executed

				oe or Print in B state of Maryland	d / Departr		lealth and I	Mental Hy			28599
	Physici	an	1. Decedent's Name (First, Middle, Last)		-			2. Date of Dea Month	Day	Year	3. Time of Death  3:40 A M
	/Medic	cal	Casimir John Seato  4a. Facility Name (If not institution, give stre	Location of Death			2010 ity of Death	P			
	Examir	ier	FRANKLIN SQUARE 1	HOSPHAZ CE	enter	Rose	dale			AHM	xe
	Funeral Director		215 12 4513	7. Age (In yrs. k		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 19	Year) 1916	9. Birthpla Count unl	
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location	on				10	Od. Inside City Limits
	e Mary	ctor	Maryland Baltimore	1	Middle R	iver					1 ☐ Yes 2 No
	with th	Director	10e. Street and Number		1	of. Zip Code 212	20		0g. Citizen of What Country?  USA		
)	ns 23	Funeral	10113 Bird River Rd.	Was Decedent Ever in U.S	S. 13. Was	Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. R	ace - America	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Midral Evarciae court by nulfited at once.	b	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2XNo If Yes, Give Year or Dates:		s, specify Cuba Yes 2⊠No	an, Mexican, Puerti Specify:	о нісап, етс.)		lack, White, e	
5-0	72 ho "natur	etec	15. Decedent's Educati (Specify only highest grade co	on ompleted)	16a. Decedent (Give kind	s Usual Occup of work done	ation during most of word d)	king	16b. Kind of	Business/Ind	ustry
212	within iene. <b>than</b>	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ssemble			Aer	ospace	<b>à</b>
	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sum	ame)	
Zar C	ould by Menta arked	To	Unk.	Seato	T		Unk.				
Maryland	and 2 sh lealth and m 27 is m		19a. Informant's Name/Relationship (Type. Wendy Anne Tiburzi	(Granddaughte	er) 121	7 Water	and Number or Ru	Baltimo	ore, Ma	ryland	1 21221
Jore	ages 1 nt of H : If ite		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Rem		lace of Dispositio emetery, cremato red Heart			2010		n - City or Tov	Maryland
Baltimore,	nit. Partme artme ortani Injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	0 0			1				
ä	Depar Impo any Ir		John W. Ru	Kouske	140	7 old i	ss of Facility Ci Funera Castern A	venue Es	ssex, N	Marylar	nd 21221
	Physician /Medical Examiner		23a. Far 1. Enter the disease, or complicate shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	ions that caused the death cause on each line.  Pheumo  Due to (or as a consequing the consequin	MIA uence of):		ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequ	ence of):	Jinc	C11011				
P.O. Box (	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 🗆 Ec	topic pregnanc her (s <i>pecify</i> ) _	ey .			Date of delive Month	ery Day Year
	that the		Part II. Other significant conditions contrib	outing to death but not resu	ulting in the under	lying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to th	ne cause of death?
rds	quires en sigr uld be	ed by						1 🗆 `	res 2 □ No	3 ☐ Prob	pably 4 Unknown
Division of Vital Records,	The law re ite has bee age 2 sho	Completed						24a. Was autop perfo 1 □ Yes	an 24 psy rmed? 2 2 No	b. Were autop prior to cor death? 1 \( \sum Yes	psy findings available mpletion of cause of
/ita	clan: ertifica	Be C	25. Was case referred to medical examiner?			l au		ath (Check only o	-		
of o	Physic this crail dire	2	TLI Tes ZINO	pital: 1 npatient 2 2	ER/Outpatient 3 28b. Time of	DOA Oth	4 Li Nursing F	forme 5 ☐ Resi			у)
on	th. : After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wor	k?  Yes 2□No	Zod. Describe	low injury occ	dired	
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	- Could not be	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street,	factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	e Hospita 124 hours e Funera detely fille	Medical C									tated. the cause(s)
	To th To th	Me	Joseph 10 11-1	79	MIZ	29c Licens		-	29d. Date sig	IBER,	12,2010
9;			30. Name and address of person who comp	oleted cause of death (Item 11 MD 9 22. Registrar's Sign	n 23a) (Type, Prin	mKIIN	Square	Dave,	Bathr	note	MD alds!
	Sta Registi	_	31. Date filed SEP 1 3 2010	2. Registrar's Signa	bank.						
* DH	IMH 17 Rev 1/2	-		1	7						

DHMH 17 Rev 7/2009

State Registrar

SEPTEMBER

SZMURLO

CHARLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 2860 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 979/2010 Donald Lee Scott, Sr. 8:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5929 Oueen Anne Street Baltimore Baltimore Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 1 🕅 M 2 🗆 F Months Hours 1/24/1950 West Virginia Director 60 Yrs. 215-54-2451 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Baltimore MD Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5929 Oueen Anne Street 21207 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance Man Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Scott Virginia Shaver permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 5929 Queen Anne Street, Baltimore, MD 21207 Nettie J. Scott / 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 9/11/2010 Ponation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. Si nati re of Funeral Service Lice is e 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ cell disease or condition resulting in death) small Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the a d be detached f Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy performed Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ျှ Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending eral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Monts Page

Pegistrar's Signature

Grene St Baitimus, mb21201.

who completed

13 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sep 7, 2010 Dorothy Loretta Shipley 4:19 а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Ellicott City** Howard 5330 Dorsey Hall Drive Hours Min. 8. Date of Birth (Month, Day, Year) Jul 16, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 M 217.12.6950 87 **Director** Yrs. Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the M-dical Examiner must be notified at once. 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5330 Dorsey Hall Drive #106 21042 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: white 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) CLERICAL administrative assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **Thomas Kennard Morris** Mildred Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 Pine Sap Dr. Houston, Mr. Frederick E. Shipley TX 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Remoyal from State Meadowridge Memorial Park, 4 Elkridge, Maryland Donation 5 Other (Specify) 22. Name Stack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Ser art 1. Enter the disear, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final DIADETES Physician/ sease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury PERTENSION Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown s certificate has been si lirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Other Sursing Home 5 Residence 6 Other (Specify) ရှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 🗌 Pending n 24 hours after death.

e Funeral Director: As bleted filled in by the fu 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Agrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIII.mm SAWAY ND 2450 Kn011 North, Dv. Columbia MD 21045 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:22 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie **Baltimore Washington Medical Center** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Jan 1, 1927 Davs Hours 052.20.9467 New 1 **Director** Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryiand ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Brooklyn 1 Yes 2/X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3600 5th Street 21225 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Apried Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 3/27/1945 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: 1/16/1946 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) mechanic machinery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Raymond Warden Beryl E. Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen M. Warden - son 3600 5th Street Baltimore, MD 21225 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o once. cemetery, crematory or other place)

Lakeview Memorial Park 1 Burial 2 Cremation 3 Removal from State Sep 09, 2010 Sykesville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Furteral Service Lice 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Mendelle lec MUUS3. Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final VENTRICULAR Physician/ ARRHYTHMIA disease or condition resulting in death) -60 MIN Medical Due to (or as a consequence of): **Examiner** OVER 2 4090 ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Be Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗆 No 9 Unknown 9 Unknown P.O. E Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown RENAL FAILURIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONCC 24a. Was an To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s autopsy performe 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Sulcide iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

GLEN BURNLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1406

CRAIN

09/08/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. - State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ Year Medical OMALD 010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Linthicum <u>Tate Hospice House</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Aug. 19 1927 New Jersey 83 Director 145-20-6199 Usual Residence of Deceder 28a-f shov be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director New Jersey Middlesex Edison 1 🗆 Yes 2 💢 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4 Montview Rd. 08837 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. ò 1 Never Married 2 x Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Director of Info. Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ၉ Kenneth B. Whitehead Mabel V. Kahler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Montview Rd. Edison, N.J. 08837 Ann Whitehead/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Woodbridge Mem. Park | Sept 15 2010 Woodbridge, N.J. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. eral Service 4001 Ritchie Hwy. Balto. Md. 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final n et and Death Physician/ Ces disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death
Unknown signed by the a d be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hoc nours after death.

neral Director: After this or
d filled in by the funeral dire 2 No မ 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident
Suicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours

To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner only one) 29b. Signature and title of certific her 102010

State

Name and address of person

31. Date filed

DHMH 17 Rev 7/2009

Registrar

who completed cause of death (Item 23a) (Type, Pric

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylar	nd / Depa	artment <i>tificate</i>			and M	1ental Hy		20	in	2860	5
			Registrar  1. Decedent's Name (First, Middle	, Last)			incate	OI D	catir		2. Date of De	Reg. N	0.4	- 0	3. Time of Death	_
	Physicia Medi		Rebecca				You	ıngei	r		Month Septem	ber	3, 20	Year 10	11:52 A	Λ
	Examir		4a. Facility Name (if not institution	-		4b. City, Town, or Location of D					•	4	c. County o	f Death		
1	1		Prince George		Cheverly					F	rince					
	Funeral Director		5. Social Security Number 228-74-1814	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. I	ast birthday) Yrs.		1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da April	rth av, Year)	1051	9. Birthr	lace (State or Foreigi ry) {inia	n
			Usual Residence of Decedent								April	19,	1951	VIT	ginia	_
	land show	ģ	10a. State 10b. County		10c. Cit	y, Town or Loc	cation							1	0d. Inside City Limits	3
	Mary 28a-f otifie	irec		e George's	L	andover	:								1 ☐ Yes 2 🕵 N	0
	th the 3a or t be n	를	10e. Street and Number				10f, Zip (					_	itizen of Wh	at Coun	try?	
	ath wi	Funeral Director	1722 Bright Sea	12. Was Deced	ont Ever in III	S 112 V		)785	nania Oria	rin? (Sno	oifu You or No	US				
တ	er deg or ite niner	by Fi	1 X Never Married 2 Mar	Armed Ford	es?	5.   15. V	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>			
Š	ırs aft ıral", I Exa	ted k	3 Widowed 4 Divorced	If Van Civa		1	☐ Yes 2	No IX	Specify:				Specify:	B1a	ıck	
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ها تو	l be fi fental rked tic ev	욘	Jim Younger								avis	,				
. of 8√ea.st Maryland 21215-0036	should and M is ma		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (	Street a			Route Numbe	er, City o	or Town, Sta	te, Zip C	ode)	_
	nd 2 sealth m 27		Frances Dixon -	- Sister		6704	Arlen	e Di	rive,	Cap	itol H	eigh	ts, M	D 2	.0743	
CANCER Baltimore, I	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation	3 Removal from S	20b. F	lace of Dispos emetery, crem	sition (Name natory or oth	e of er place	)		ate	20c. l	_ocation - C	ity or To	wn, State	
ま Ein Ein	it. Pag rtmen rtant: njury		4 Donation 5 Other (S	pecify)	<u>C</u> th	emetery, crem erryst urch C	eme te	ry	st i	09-1		Cha	tham,	Vir	ginia	_
م <u>Ba</u>	perm Depa Impo any i		21. Signature of Funeral Service L	icensee 0 0	00					-	ler Fu				24557	
			23a. Part 1. Enter the disease, or	complications that ca	used the deat										Approximate	
	Physician/	0.5	shock, or heart failure. List of Immediate Cause (Final			Breast		Mod	taata	oio					Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	a	r as a consequ		WILII	net	Lasta	818				_		_
	Examiner	L	Sequentially list conditions	h .												
4	p #	nine	Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or iinjury	Due to (o	r as a consequ	uence of):										
	ecute and I-trans	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c	r as a consequ	uence of):										_
0	cate be executed physician and the burial-transit	dical				,										
3760	ficate g phy as the	Nedi		- a												_
Box 687	endin use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna	ncy Il death 3 🗆	Ectonic m	eanancy				-	23d. Date	of delive	ry	
<b>B</b> 0)	death he att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ঐ No 9 ☐ Unknown		ant at time of o		Other (spe						Mont	h	Day Year	
P.O.	at the d by t etach		Part II. Other significant condition			ulting in the ur	nderlying ca	use aive	n in Part I	_	220 Did t	abassa	una nantrib		e cause of death?	
σ.	signe signe	d by	, a	ing to do	an bar not roo	aning in the di	raorijing da	acc give	,,,,,,,	•					ably 4 🖾 Unknown	n
ğ	requi been should	lete			-						24a. Was				sy findings available	
ပို့ မ	e has	Completed									auto perfe	psy ormed?	pri de:	or to con ath?	npletion of cause of	
<u>=</u>	an: Th tificat tor, pa	BeC	25. Was case referred to medical	<u> </u>				26. Plac	ce of Deat	h <i>(Check</i>	1 \( \text{Yes} \)	2 X N	io 1 L	Yes	2 ∐ No	
Z.	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 🎇 No	Hospital:	patient 2 💢	ER/Outpatient	3 🗆 DOA	Othor			ne 5 🗆 Resi	dence	6 🗍 Other	Specify)		
of	ing Ph fter th ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of (Month)	injury Day, Year)	28b. Time of injury	280	c. Injury work?	at		8d. Describe I					
io	ttendi death tor: A the fu	Certificate:	2 Accident Investig	ation			М		′es 2 🗆							_
Division of Vital Records,	after Direc	Cer	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (3 City or Tov			or Rural .	Route Number,	
Ω	spita hours neral d fillec	ical	29a. Certifier 1 🖾 Certifying	Physician: To the bes	at of my knowl	edge, death o	ccured at th	e time, o	date and p	olace, and	d due to the ca	iuse(s) a	nd manner:	as stated	I.	_
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and								the time, date a	and place	e, and due to	the cau	se(s) and manner state	ed.
_	To t		29b. Signature and title of certifier					icense :					ate signed (/			
			11111	MO				51	520			00	7-07	- 2	010	
1			30. Name and address of person v Bahram Pishdad			, , , , ,		210	LIC C	hina	tor D	າ າ	0032			
,	Stat	e	31. Date filed (Mort/PDay Y31)	A Rec	istrar's Signat	ere .		210,	was	ning	LOH, D		0032			
1	Registra	ir	3EP 132	110 Penge	w B	par	Ked									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23aft1, 11 per dr. 18914,04/08/2011 and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DAVID GERARD ZELLER Septemeber 5. 3:22 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 5003 Broadmoor Road Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X**□ M 2 □ F Months Days Hours Min Aug<sup>nt</sup> 1 1°, 1°950 215**-**56-2650 60 Director Mary Tand Usual Residence of Decedent Show 10b. County 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director N/A 28a-f Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 5003 Broadmoor Road 21212 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give 68-Black, White, etc. 1 ☐ Never Married 2 🕅 Married ò þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Construction estimator Highway construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Norbert Henry Zeller Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Deborah A. Zeller 5003 Broadmoor Road, Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St. compay crowd of the plassumption Church Cemetery 9/10/2010 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Si atra frunz se o Licen ee rartin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Ischemic Heart Disease** Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of) Coronary Artery Atherosclerosis Examiner Secuentially list nanditions if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ☐ Pregnant a ☐ Unknown signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Liver Disease, Hepatic Encephalopathy, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? Type II, Type II Diabetes Mellitus 24a. Was an autopsy After this certificate has funeral director, page 2 s performed 1 Yes 2 No 2 🗓 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Cath 28b. Time of 28c. Injury at 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

132010

Charles Harrison, MD, 6095 Marshall Lee Drive, Suite 100, Elkridge, MD 21075

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0102\_E2-90 Yvonne Margo Amaker 2132 p<sup>™</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery <u>Silver Spring</u> Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🗶 F 578-68-4393 Months Hours Min. Director 60 D.C. Usual Residence of Decedent 28a-f show 10a. State 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was a 28 or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits D.C. Washington 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3905 9th St. SE 20032 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Simon P. Amaker Ella T. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Amaker / brother 9301 Locksley Rd., Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 08-28-2010 Brentwood, MD . Signature of Funeral Service Ocen e 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd₁ Camp Springs₁ MD 20748 23a. Part4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ Onset and Death Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Aspiration of Emesis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Progressive Renal Failure that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Diffuse Ovarian Cancer Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death
☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav 1 Yes 2 9 Unknown the been signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>a</u> 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2: autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) Director: After t d in by the funera 28c. Injury at work? 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending ☐ Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D67589 08-24-2010

DHMH 17 Rev 7/2009

State

Registrar

1500 Forest Glen Rd., Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Harold V. Lawson

31. Date filed (Month, Day, Year)

AUG 3 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28608 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** TSarr 8:42 A M 24 2010 4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Hosp tal 412 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 □ M 2 🗹 F Hours Months 59 265-88-9068 Yrs 31-1950 Florida Director Usual Residence of Decedent 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show aminer must be notified at 1 ☐Yes 2 ☐ No Prince Director George Maryland Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11315 20735 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No other traumatic event, the Medical Examiner Black White etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 9 Black 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Buard George 2 should be filed within 72 and Mental Hygiene.
Is marked other than "n: Prince Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lowhsend 2 and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an of Health a C H4250-0 11315 Marcelles 20231 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important; If its any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 2-10 4 ☐ Donation 5 ☐ Other (Specify) Kesurrection em 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MI) 20108 no 1589 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. I or complications that cau ist only one cause on ear if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Suaden hour disease or condition resulting in death) /Medical xaminer 4 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed and as the burial-trai resulting in death) Last as a consequence of): or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, o 1□Liv∈ 4□Pre nome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month int at time of death 5 Other (specify) signed by the sid be detached f 9□ Un νn 9 Unknown Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? eath but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No Were autopsy findings available prior to completion of cause of death?
1 □Yes 2□ No has page 2 autopsy this certificate 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 2**X** No Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 Yes 2 No ours after death.

neral Director: A
filled in by the fu 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010

Registrar

State

rav

31. Date filed (Month, Day, Year) AUG 30 2010

BBS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

2225

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29ay 2010 09:30 AM Margaret E. Butler August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Cecil North East Sunny Acres Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) ct. 19,1922 1 □ M 2 □ KF Months Hours Country) Virginia Director Oct. 183-12-4967 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was a 28a-f sho item 8.23a or 28a-f sho item 8.2 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cecil E1kton Maryland 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Pettinaro Drive Apartment C-3 21921 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3¥¥Widowed 4 ☐ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Eleanor (Unknown) ည James Harris Wright permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2192119a. Informant's Name/Relationship (Type, Print) 300 Pettinaro Drive, Apartment C-3, Elkton, Maryland Barbara Butler / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September cemetery, crematory or other place) 1 🖺 Burial 2 □ Cremation 3 □ Removal from State 5 injury o 4 Donation 5 Other (Specify White Chapel Gardens: 4, 2010 21. Signatur 22. Name and Address of FacilityCrouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List Immediate Cause (Final Atherosclerolie Heart Disease Inset and Death Physician/ disease or condition resulting in death) years Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by erebrevascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has page 2 autopsy performed? Yes 2 N death? 2 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending work Accident 1 Yes 2 No Investigation completed filled in by the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Stielder S MI) 100233322 8.30.2010.

Registrar

DHMH 17 Rev 7/2009

State

ElbJen MO 2/92/.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. Sachdev MD 126A, Ethor ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Zolear 102744 Medical 4c. County of Death give street and number) Town, or Location of Death **Examiner** Marylanc INTO If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗹 F Months Hours Canada (Month, Day, **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director · 28a-f NON 1 Ves 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a anada almat 20' 51 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Vivorced If Yes, Give Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) eacher ducation Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) and Mental Fis marked of 2 H, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code nt of Health a CHINDS CALLIN 690 dentree UCIDOON SHAD (1205hten 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 31-2010 Kiverdale RIC sivendale 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fluneral Service Lice 22. Name and Address of Facility JISEMON JUH PL Campsphings 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to provide cause. Enter Underlying Cause (Disease or iinjury Examiner the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending properties for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 I Inknown P.O. signed by ti significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has blirector, page 2 s autopsy Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral of Death Certificate: 27. Mann 28b. Time of s after death.

al Director: After tlad in by the funera 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours at To the Funeral D completed filled is Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

St St

State Registrar 4467

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kou

31. Date filed (Month, Day, Year)

AUG 3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2.0.1.0.

			For State Registrar	State of Mar	Cer	tificate of D	eath		eg. No.	UIU	28611
	ysicia		Decedent's Name (First, Middle, La  COSTINA	st) D.		BROWN		2. Date of Deat Month	Day	Year	3. Time of Death
	Medic camin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Death	AUGUST		2010 nty of Death	7:47 P M
1			SOUTHERN MARY	LAND HOSPIT	AL	CLINTO	N			CE GEO	RGE'S
	neral ector	8	5/9-/0-3394	7. Age (li	n yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/24/1	Yea <i>r</i> ) <b>954</b>	9. Birthp Count WEST	lace (State or Foreign ry) VIRGINIA
and	të	or	Usual Residence of Decedent  10a. State 10b. County	11	Dc. City, Town or Loc	cation					Od. Inside City Limits
Maryla 28a-f	otified	Director		GEORGE'S	SUITL	AND					1 X Yes 2 ☐ No
th the	t be n	ral D	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	of What Coun	try?
ems 2	r mus	Funeral	3716 SWANN ROAD	12. Was Decedent Ever	r in U.S. 13. V	2074 Vas Decedent of His		cify Yes or No-	USA	lace - America	an Indian
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho	other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 █ <b>X</b> No If Yes, Give Year or Dates.		Vas Decedent of His Yes, specify Cuban ☐ Yes 2 【XNo		Rican, etc.)	В	Black, White, e	tc.
<b>15-(</b> 72 hou n "natu	Aedica	Completed	15. Decedent's E (Specify only highest gr		(Give k	ent's Usual Occupa	ition uring most of working	ng	16b. Kind of	f Business Ind	ustry
212 within giene. er tha	the h		Elementary/Seconday (0-12) 1 2TH	College (1-4 or 5+)	- 1	D NOT use retired)  LD CARE P	ROVIDER		GOV	VERNMEN	JT'
land be filed ental Hy ked oth	event	To Be	17. Father's Name (First, Middle, Last)  RAY FIELD AVE	DV	-		18. Mother's Name	, , ,	laiden Surna		
Maryland 2 should be filed Ith and Mental Hy 27 is marked ott	umatic		19a. înformant's Name/Relationship (7		19h Mailin	g Address (Street ar		B. PRES		State Zin C	
e, Ma and 2 st Health a	ner tra		ALEX BROWN/HUSBA	AND	3716	SWANN ROA	AD SUITLA	ND, MARY	LAND 2	20746	
			20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of latory or other place	) :			n - City or Tov	
Baltimo permit. Page Department Important: II	/injun	7	4 ☐ Donation 5 ☐ Other (Special 21. Signi-ture → Francis Service Lice > 8			LN CEMETI Name and Address		2010 I			RYLAND I. HOME
D be E	an o	-	11 6	- 2		474 LANDO	OVER ROAD	LANDOV	ER, MAR	RYLAND	20785
Physic Med Exam	dical iner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	r IV	Lv15	, such as cardiac o		st, 		Approximate Interval Between Onset and Death
ъ	#	Examiner	Sequentially list conditions, if my leading to immediate cause. Enter Underlying	Due to for as a co	r sequence of						
xecute	al-trans	Exan	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):						
5760 ficate be executed g physician and	ne buri	Medical		d							
<b>Box 68</b> death certifient attending	ched for use as the	= I	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknovn	23c. If yes, outcome of p 1  Live Birth 2 4  Pregnant at tim 9  Unknown	Fetal death 3 🔲	Ectopic pregnancy Other (specify)				Date of deliver	y Day Year
Hecords, P.O. The law requires that the ate has been signed by the control of the	be detar	2	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the un	derlying cause give	n in Part I.				cause of death?
Ord; v requii	should	lete					·	24a. Was an			sy findings available
Hecords, The law requires ate has been sig	page 2	Completed						autopsy perform	ed.	prior to com death? 1 \( \text{Yes} \) 2	pletion of cause of
VITAI ysician: is certific	ector,	Be .	25. Was case referred to medical examiner?	Hospital:	1		ce of Death (Check		<u></u>		
OT V  19 Phys  2er this	eral dir	e:	27. Manner of Death	1 Inpatient 28a. Date of injury	28b. Time of	3 DOA Other:	4 L Nursing Hon	ne 5 Residen 8d. Describe how			
eath.	the tun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		<i>ar</i> ) injury	work?	es 2 🗆 No		injury cood	.,,,,,	
DIVISION ital or Attendir after death.	led in by		4 Homicide determined	28e. Place of Injury - building, etc. (S		et, factory, office	2	8f. Location (Stre City or Town,		ber or Rural R	Poute Number,
DIVISION OT VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific	npleted til	Medical	(Check 2 Medical Examination only one) 3 Certifying Nurs	ician: To the best of my finer: On the basis of examile Practioner: To the best	ination and/or investic	ation, in my opinion.	death occurred at t	he time, date and	place, and d	lue to the caus	e(s) and manner stated
To with	100		29b. Signature and title of certifier	<b>~</b>		29c. License n	LO55	29		ed (Month, Da	
12-	5		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type, Pri	int) He Rd	01.01	m m	1 1	072	
Rec	State gistra		AUG'3'0'2010"	32. Registrar's S	Signature	<u></u>		~,,111	174	013	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 20 YO ADAVIRGINIA BAGOT 5:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 7 F Days Hours 578-80-1134 MARCH<sup>Pay</sup>16<sup>ar)</sup>1919 Director 91 Yrs. GOYANA Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD MONTGOMERY SILVER SPRING ₹ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 801 WINDMILL LANE 20905 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced Completed BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other tl TEACHER PRIVATE e 1 and 2 should be filed w of Health and Mental Hygi If item 27 is marked other or other traumatic event, in Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည KENNETH BAGOT ADA V. VAN SLUYTMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNETTE BERKELEY/DAUGHTER 801 WINDMILL LANE SILVER SPRING, MARYLAND 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) if it 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) of**HEAVEN** 8/30/2010 SILVER SPRING, MARYLAND Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Op not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ METASTATIC CECAL CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner FAILURE TO THRIVE Sequentially list conditions, cian/Medical Examine if any, leading to intrinediate cause. Enter Underlying Cause (Disease or iinjury Day to (or as a consequence or). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 🛛 No Physic been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate ! 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 🕅 No Other: မ Director: After this in by the funeral dir 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medica Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) D60826 AUGUST 26, 2010 shan

State Registrar

32. Registrar's Signature

1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND

20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KSHAMA GARG M.D.

AUG 30

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	,		1 - State of Maryland / Dep	artment of Health and Nertificate of Death		iene 0 1 0	28613
	Physici	an	1. Decedent's Name (First, Middle, Last)  Betty Byram		2. Date of Death Month August	27, 2010	3. Time of Death 6:00 AM
	/Medid Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
.,"			Heartland of Adelphi	Adelphi		Prince Ge	
	Funeral Director	0)	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 579-34-5412 1 M 2 X F 80 Yrs.	) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Pay. 7/16/19	Year) Co	thplace (State or Foreign bunkry) Shington, DC
	ס		Usual Residence of Decedent		.,,		
	daryla f shov	jo	10a. State   10b. County   10c. City, Town or L				10d. Inside City Limits 1√2 Yes 2 □ No
	r 28a-	irect	MD Calvert Chesapea  10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	
	23a o	ralD	PO Box 754	20732		United Sta	ites
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Maclical Exemples must be notified at	<b>Funeral Director</b>	11. Marital Status 12. Was Decedent Ever in U.S. 13 1 □ Never Married 2 □ Married 1 □   Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
036	urs afi al", or Exem	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi	ite
5-0	72 ho	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation skind of work done during most of work	ina 1	6b. Kind of Business	
121	within iene. <b>than</b>	duc	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) are Provider		Private	
Dd 2	al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, M		-
ylar	ould be Menta arked aric e	To E	Chester Maske	Dorothy			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marian Experiment and be notified at once.		19a. Informant's Name/Relationship (Type. Print)  Gloria Boone ( Daughter )  19b. Mail  PO Bo	ing Address <i>(Street and Number or Rur</i> x 754 Chesapeake	al Route Number, Beach, M	City or Town, State, . D 20732	Zip Code)
ore,	ges 1 a t of He If item or othe		20a. Method of Disposition  1 Burial 2 Coremation 3 Removal from State	osition (Name of Imatory or other place)	Date 2	Oc. Location - City or	Town, State
Ħ.	it. Pag rtment rtant: njury o		4□Donation 5□Other (Specify) Fort Lin	coln Crematory 8/3			
Ba	permi Depa Impo any ii			2. Name and Address of Facility <b>For</b> 401 Bladensburg Ro			
Ę			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
F	hysician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Arrythmia				weeks
ľ	Examiner		Due to (or as a consequence of):  Myocardial infarc	tion			15 mins
	±. g	iner	Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury Hypertension				
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Cc.  Due to (or as a consequence of):				years
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E	d d				
68	ng ph)	Medi	IF FEMALE:				
Вох	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy		23d. Date of de Month	livery Day Year
P.O.	at the de by the a tached i	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			Day Tou.
S, D	es that igned b		Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	w require s been sign should b	ted	Chronic Renal Failure		1 ☐ Yes	s 2 No 3 P	robably 4 🗌 Unknown
Division of Vital Records,	has b	Completed by	Dementia		24a. Was an autopsy perform	prior to	ntopsy findings available completion of cause of
tal	certificate h		25. Was case referred to medical	OS Plans of Death	1 □ Yes 2.	XINo   1 □ Yes	2 □No
Į .	this cer al direct	Fo Be	examiner? 1 ☐ Yes 2 ☒ No	26. Place of Deatl nt 3 DOA Other: M Nursing Ho			cify)
0 1	Tige Affer	on:	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 1 28b. Time of Injury	f 28c. Injury at Work?	28d. Describe hov		
ISIC	death. ctor: / y the fi	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, st	M   1 □ Yes 2 □ No	28f Location (Stre	eet and Number or Ri	umi Pouto Number
בַּ		Certification: To	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town,	State)	na Houte Number,
300	vithin 24 hours after to the Funeral Director to the F	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and due	s stated. to the cause(s)
1	vithin To th comp	Me	29b. Signature and title of certifie	29c. License number	29	d. Date signed (Mont	h, Day, Year)
7			· Atagi	D19609		6.27	2010
R	2		30. Name and address operson who completed ause of death (Item 23a) (Type, Raman Tuli, MD 10810 Darestown Roam		hersburg	, MD 20878	3
	Sta Registra	_	31. Date filed (Month, Day, Year)  AUG 3 1 2010  Server 32. Registrar's Signature				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State	State of Ma	arylan		irtment of F tificate of L		d Mental Hy	2	nin	28614
Dhusisia	~./	Registrar  1. Decedent's Name (First, Middle, L	- 107	- 1	Cer	incate of L	Jeain	2. Date of Do		Year	3. Time of Death
Physicia Medic Examin	al	4a. Facility Name (if not institution, gi	BOLUE	=1/		4b. City, Town, o	r Location of D		Day 25	2010	135 A M
, 		UNIV 6F MARYAM	UD MEDILA	LO	ENTER	BAL 1	TIMORE If Under 24	<u> </u>	BAI	LTIMORE	
Funeral Director		216-50-8177		62	ast birthday) Yrs.	Months Days		Min. 8. Date of Bi		7 MARY	place (State or Foreign
land show dat	tor	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	ation					10d. Inside City Limits
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ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  It of Health and Mental Hygiene.  It of Health and Mental Hygiene.  It is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		MARYmant's Name/Relationship NOELLA BOLDEN /	(Type, Print) WIFE					RANDYWINE			Code) 20613
Page 1 and ment of Hea ant: If Item ury or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐ Removal from State	C	emetery, crem	sition (Name of atory or other plac		Date		tion - City or To	
t. Pa tmei rtant ijury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service) ice	0.4	MAKY				PT. 1, 2010			MARYLAND
permi Depar Impor any ir		LADIA C. THORNION			3	439 LIVI	NGSTON	ROAD, IN	DÎAN H	EAD, MA	RYLAND 2064
Physician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	y one cause on each line.		_		>.A		rrest,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	Due to (or as a			1 1 -		en optupsis			Imonth
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a		ence of);	leukemio	(				2
e executed ian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Mutiple Due to (or as a	consequ		nos					2 years.
e <u>re</u> :		resulting in death) Last	d	oonooqu							
ertificate ding ph se as th	/Мес	IF FEMALE:	23c. If yes, outcome of	of pregnar	ncv				00.	Data of dalling	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Laureral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnand Other (specify)	су		230	d. Date of deliv Month	Day Year
that the ned by e detacl		Part II. Other significant conditions	contributing to death bu	t not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
equires een sig nould b	Completed by	Hypertension							Yes 2 🗹		bably 4 Unknown
ne law r te has b age 2 st	ompl	End Stage Re	nal disea	10,					psy ormed?	prior to co death? 1 \Boxedath Yes	psy findings available impletion of cause of
cian: Tł ertificat ector, pa	Be	25. Was case referred to medical	Hospital:					1 □ Yes Check only one)	2 La No	□ Yes	2 🗆 NO
Physi r this c eral dire	e: To	1 ☐ Yes 2 ☑ No 27. Manney of Death	1 I Inpatie	/	ER/Outpatien 28b. Time of	28c. Injur	4 ∐ Nursir	ng Home 5 Res 28d. Describe			/)
tending leath. or: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	the		injury		(? Yes 2 ☐ No —				
af or At s after o I Direct d in by		4 ☐ Homicide determine		y - At hoi <i>(Specify)</i>	me, farm, stre )	et, factory, office			Street and No wn, State)	umber or Rura	l Route Number,
Hospit 24 hour Funera sted fille	Medical	(Check 2 Medical Exa	hysician: To the best of n miner: On the basis of ex	amination	and/or investi	gation, in my opinio	on, death occur	red at the time, date	and place, an	d due to the ca	use(s) and manner stated
To the within to the To the comple	Ž	only one) 3 ☐ Certifying No 29b. Signature and title of certifier	urse Practioner: To the b	est of my	knowledge, d	29c. License		d place, and due to t	29d. Date s	igned (Month,	Day, Year)
		1			cian		232	3492	8-	25-2	010
31041		30. Name and address of person who	S. Greene	St	. Balt		ND				
Stat Registra	e	31. Date filed (Month, Day, Year) AUG 30 201	32. Registrar	's Signat	ure Leve	w.					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar		State o	ı ıvıaryıar		rtificate of		ivientai Hy	giene Reg. No. 20	10	286	15
	Physicia		1. Decedent's Name (Fi	irst, Middle, Last	t) Lee		Blacke	ar	Sr.	2. Date of De Month SEPTEM		ŏiro	3. Time of Death	n M
	Medic Examin		4a. Facility Name (if not		street and numi	,		4b. City, Town, o	or Location of Dea		4c. County	of Death	7 13.30	
	Eunoval		WMHS - REG			CENTER  7. Age (In yrs.		CUMBERL If Under 1 Year		s. 8. Date of Bir	ALLEG			
e de la constante de la consta	Funeral Director		218-38-01	31	M 2 □ F	67	Yrs.	Months Days	Hours Mir	(May	29, 1943	9. Birthp	place (State or Forei try) MD	ign ——
	/land f show	ţō		b. County		10c. Ci	ty, Town or Lo	cation				1	0d, Inside City Limi	its
	e Mar r 28a- notifie	Director	MD 10e, Street and Numbe	Alleg	any		Cu	<u>mberland</u>					1 □ <b>x</b> Yes 2 □	No
	with th			lder Stre	e t			10f. Zip Code	21502		10g. Citizen of W	hat Coun JSA	try?	
	death vitems	Funeral	11. Marital Status		12. Was Deced	lent Ever in	SO - 13. 1	Was Decedent of F f Yes, specify Cub	lispanic Origin? (S	Specify Yes or No-	14. Race	- America		
Maryland 21215-0036	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 Never Married 3 Widowed 4	2 ☐ Married	Y Ses If Yes, Give Year or Dat	<sup>2 □ №</sup> 196		Yes 2 No		to Rican, etc.)	Black Specify:	κ, White, ε	hite	
15-(	72 hou n "natu dedica	nplet	1: (Specify	5. Decedent's Ed only highest grad	lucation de completed)		16a. Dece	dent's Usual Occup kind of work done	during most of wo	orking	16b. Kind of Bus			
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pu	ntal Hyg ed other: event,	To Be	17. Father's Name (First	, Middle, Last)				<u> </u>		ame (First, Middle,	Maiden Surname)			
ryla	should be n and Ment ris marker raumatic e	F		n Blacke							larbaugh)			
	2 sho Ith an 27 is 'trau		19a. Informant's Name	Blacker		daughte		ng Address <i>(Street</i> 27 E. Elde			r, City or Town, St	. ,	,	2
Baltimore,			20a. Method of Disposit	tion		20b. F	Place of Dispo	sition (Name of natory or other place		Date	mberland 20c. Location - 0			<u>-</u>
tim	t. Page tment o tant: If jury or		4 Donation 5					morial Park	- i	9/7/2010	Cuml	perla	nd Mi	ם.
Bal	permit. Page Department Important: If any injury or once.		21. Signature of Funera	I Service License	Capo	els	22	Name and Address Scarpelli 108 Virg	ss of Facility Funeral Ho inia Avenue	me, PA : Cumberlar	id, MD 21502			
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Box 68760	ificate ig phy as the	Medical	IE EEMAL C		a						1			
99 ×	th cert	ian/	IF FEMALE: 23b. Was decedent preg in the past 12 mon	giiaiii.		irth 2 🗌 Feta	al death 3	Ectopic pregnanc	у		23d. Date		*	
8	requires that the death certific been signed by the attending p should be detached for use as	by Physician/N	1 Yes 2 No	>	4 ☐ Pregna 9 ☐ Unkno	ant at time of o	death 5 ∟	Other (specify)			Mont	th I	Day Year	
P.0.	that the	by PI	Part II. Other significan		ntributing to dea	ath but not res	ulting in the u	nderlying cause give	ven in Part I.	23e. Did to	obacco use contrib	ute to the	cause of death?	
ds,	equires	ted	Atrial fib	rillation						1 🗆	Yes 2 □ No 3	B 🗌 Prob	ably 4 Unknov	۸n
000 000 000	has by	Completed								24a. Was autor	osy pri	ior to con	sy findings available apletion of cause of	e f
Ě	sician: The k certificate hi		25. Was case referred to	medical				26 DI	ace of Death (Che	1 🗆 Yes		eath?	2 No	_
Zit?	Physicia this cert al direct	To B	examiner? 1 \( \sum \) Yes 2 \( \bar{\text{X}} \) No	, Н	lospital:	patient 2	ER/Outpatien	041	or.		lence 6 🗆 Other	(Specify)		
Division of Vital Records,		Certificate:	27. Manner of Death  1 Natural 5 2 Accident	Pending Investigation	28a. Date of (Month)	injury , <i>Day, Year)</i>	28b. Time of injury	28c. Injury work M 1 🗆	/ at		ow injury occurred			
ivisio	l or Atte after des Director	Certif	3 ☐ Suicide 6 6 4 ☐ Homicide	Could not be determined	28e. Place o building	f Injury - At ho , etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural F	⊰oute Number,	
Ω	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	(Uneck 2 🗆 r	Medical Examin	er: On the basis	of examination	and/or invest	gation, in my opinic	n, death occurred	at the time date a	use(s) and manner	n the caus	ea(s) and manner eta	ated
	o the		only one) 3 🗌 ( 29b. Signature and title of	certifying Nurse	Practioner: To	the best of my	knowledge, d	eath occurred at the	e time, date and pl	ace, and due to the	cause(s) and man	ner as stat	ted.	
	->F0		Christm	oher S	Van	si M	2	175	7998-	7	9-2-/		ay, I Cui/	
		Ì	30. Name and address of	of person who co	mpleted cause	of death (Item	23a) (Type, P	int)	,10		· · · · · · · · · · · · · · · · · · ·			
	State		Christop 31. Date filed (Month Da	her Vagr	noni	istrar's Signat	925	Seton Dri	ve Cum	berland N	AD 21502			
	State Registra	r	31. Date filed (Mont)	P 1320	10	men a digital	1. 4	arkel						

OHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.
Amend Items 4a-c per med cert G907 All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month X Physician/ 47 AN Casto 010 Georgiana Medical 4a. Facility Name (if not institution, give street and number) ty, Town, or Location of Death Cumber Land Great Cacapon 4c. County of Death **Examiner** 120 Casto Road W. MD Hosp. Center -Morgan Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 D 5 Sep 7, 1926 OH Director 283-22-7645 83 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State er than "natural", or items 23a or 28a-f sho Director WV Morgan Great Cacapon 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 25422 120 Casto Road USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. <u>۾</u> 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Specify. white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Anna Dollinger Lacy George Lacv 19a. Informant's Name/Relationship (Type, Print)

John Casto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 120 Foxtrotter Lane Ridgeley WV 26753 Son and 2 s Health a or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H
Important: If ite
any injury or ot Scarpelli Funeral Home, P.A. 1 Burial 2 Cremation 3 Removal from State 8/26/20 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Scarpelli Full eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine burial-transit that initiated events resulting in death) Last and attending physician for use as the buria Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Pregnant at time of death 5 Other (specify) ed by the a detached f Yes 2¶ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed þ wal 2 No 3 Probably 4 Unknown Records, 1 Yes Completed should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 s autopsy perform death? this certificate 1 ☐ Yes 2 ☐ No Was case referred to medic examiner? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 မ ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: 5  $\square$  Pendinginjury Natural 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Manth, Day, Year) 29b. Signature and cause of death (Item 30. Name and add (Type, Print) ss of pers State Registrar

219

State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Anthony T. Castaldo 2010 6:30 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crofton Care & Rehab. Center Crofton Anne Arundel 8. Date of Birth (Month, Day, June 13. 9. Birthplace (State or Foreigr Country) Vest Virginia 6. Sex 1 🔀 M 2 🗆 F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Hours 86 Yrs Director 235-32-9187 June Usual Residence of Decedent Show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? è Funeral 23a 940 Astern Way Unit 209 21401 items ; Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White If Yes, Give Specify: "natural", Completed 3 Divorced 4 Divorced Year or Dates. 1943-47 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Contract</u> Officer Government Printing Ofc Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Patsy Castaldo Carmela Canzano t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bess R. Castaldo/ Wife #209 Annapolis, Maryland 21401 Astern Way. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Kalas Crematory 8-21-2010 Edgewater, Maryland Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home of Funer Signature 2973 Solomons Island Rd., Edgewater, MD 21037 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate , or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 40 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit CA that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) g Unknown certificate has been signed by the a rector, page 2 should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Division of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 Yes 2 No 25 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ၉ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Oate of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Detrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month) 29b. Signature and title of certifie 20 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 222 Bowie MD 20715 Rakesh Arora. 14300 Gallont Fox Lane Srite 31. Date filed (Month, Day, Year) AUG 2 5 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner reorges nce WaShMD If Under 1 Year | If Under 24 Hrs. | 8. Oate of Birth (Month, Day, Year) ivington Birthplace (State of Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 7-88-8/0 1 □ M 2 🕽 F 48 1962 DC 19, **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, the Modical Exact for count by positive at 1 ☐ Yes 2 No Director Jeorge 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code filed within 72 hours after death with 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 Yes, Give 2 Married 2 No 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: <u>۾</u> DIack 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, I've Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 U. s. Government <u>Material Handler</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Luther A. Cary, Jr. Annie R. Washington ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4545 Wheeler Road, #209, Oxon Hill, MD 20745 Ronald Hicks - Husband Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, enwood Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. K. Johnson Funeral Home P. A. 21. Signature of Funeral Service License 6503 Old Branch Ave., Temple Hills, MD 20748 23a. Pr n. Enter the disease, or complice ck, or heart failure. List only one Do not enter the mode of dying, such as cardiac or respiratory arrest, tions that caused the death. cause on each line. Imme vie te Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 ZNo P.O. ned by the detached 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 0 No 1 🗌 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 ☐ Yes 1 Hnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certification: To Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c 28d. Describe how injury occurred After t Injury at Work? Hospital or Attending Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Amir Mirza-Alikhani, MD 11711 Livingston Road, Fort Washington, MD 20744 31. Date filed (Month, Day, Year) AUG 3 0 2010 82. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

46046

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24b per dr., g908, 10/04/2010 dhb For Amend Item 24b per ur., Registra men #24a Per Prys. PCP-1-10cm Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 22 ay 2010 ear 0510 April Jamila Clarke Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 26, 1976 1 🗆 M 2 🔀 F Months Days Hours 34 Yrs. DC 578-98-8858 Director Usual Residence of Decedent shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland notified at Director 28a-f 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be r Funeral 4306 South Capitol Street SE # 3 20032 United States ural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural" Completed 3 Divorced 4 Divorced American event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use retired) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) Private Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once. ည Veronica Caressa Clarke unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5201 Connecticut Ave. NW # 906 Washington, DC Veronica Caressa Clarke/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory of other place)
Memorial Cemetery August 28, 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 2010 22. Name and Address of Facility Stewart Funeral Home, Inc. gnature of Funeral Selvice 20019 Washington, DC 4001 Benning Road NE Plant in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Acute Respiratory Distress Syndrome Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Sepsis the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate l 2 X No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25 Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 XInpatient 2 🗌 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title di 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) August 23, 2010 D38682

State

Registrar

ack

1500 Forest Glen Road

32. Registrar's Sign

20910

Silver Spring, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steren

Albert J. Ste 31. Date filed (Month, Day, Year AUG 3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28, 20°TO 9:59 August Coleman Carrie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Days Min. Months Hours (30-15, Day 938 Chera₩, SC 74 248-60-4324 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me. it al Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Hyattsville Prince George's 1X☐ Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20782 1840 Longford Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Hospital ACT Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file ည McQueen Nellie Cuffie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1840 Longford Dr. Hyattsville, MD 20782 19a. Informant's Name/Relationship (Type, Print) Fred D.Coleman (husband) and 2 s Health Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 9/4/2010 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 XBurial 2 Cremation 3 Removal from State Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of Funeral Service 20722 Brentwood, MD 3401 Bladensburg Road 1205 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL CUTE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine ON GESTIVE countially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Pregnant at time of death cate has been signed by the spage 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion death? certificate has autopsy performed 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 XNo ည 1 Inpatient 2 1 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number AUGUST 30, 2010 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACK, MARYLAND CARRILL AVENUE, TAKOMA TERRY JODRE, MD, FACEP 7600

State Registrar Date filed (Month, Day, Ye AUG 3 1 2010

32. Recentrar's Sanatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienefor State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7/30PM Daniel R. Duff Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arunda Himore Weshington Medical Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days 1 🕱 M 2 🗆 F Months Hours Min 8/14/1931 MD 218-24-6591 79 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State iled within 72 hours after death with the Maryland Director 1 Yes 2XXNo Millersville Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21108 404 Dale RD. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Korea Black White etc "natural", or þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Union Electrician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ပ္ Annie Cattanach Daniel R. Duff Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Millersville, MD 21108 404 Dale Rd. Barbara Duff item 2 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place, 1 ☐ Burial 💥 🛱 Cremation 3 ☐ Removal from State 8/19/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Fuseral Sprice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No ō Month Year Pregnant at time of death detached the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by should be 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death? 1 Yes 2 No certificate Yes 2 A or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner eath 28a. Date of injury 28b. Time of 28c. Injury at Certificate: s after death.

I Director: After to 28d. Describe how injury occurred work? (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State 24 hours Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nu/se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 29b. Signature and title of certifi 29c. License number 103 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUDICITE FULL SHUMO, W WASKINGNIN 32. Registrar's Signature Date filed (Month) State 5 2010 AUG 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 55 A.M Doris Τ., Deakins HIGHST 2010 /Medical Facility Name (If not institution, give street and number) 4c. Qounty of Death City, Town, or Location of Death Examiner APLATA VISTA MEDICAL (enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Days 219-32-7602 92 Yrs Director October 3,1917 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5005 Port Tobacco Road 20662 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify White þ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other the any njury or other traumatic event, I'm.1 any or other traumatic event, I'm.1 Seamstress Sewing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Posey Mary Franklin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Deakins/Son 5005 Port Tobacco Road, Nanjemoy, MD 20662 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Nanjemoy Baptist Cem. 9/1/2010 Nanjemoy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. M00945 C 211 St. Mary's Ave. La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MANCH disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EUNIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

P.0. Records, 28a-f show

23a or

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"natural"

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attending physician for use as the buria

cate has been signed by the page 2 should be detached

certificate

this

After

24 hours after death. Funeral Director: A

within 2.

funeral director,

filled in by the

completely

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

s esn.

Maryland 21215-0036

Baltimore,

traumatic event, the Medical Examiner must be notified

requires that the death certificate be executed Box 68760. Division of Vital Physician: Hospital or Attending

State Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of gerson who completed cause of death (Item 23a) (Type, Print)

11345 Fembrook

29. Suite 103 WALDOFF, MD. 20603

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28623 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 24 20 TO 1:08 A M FRANCIS BEARDSLEY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S CLINTON SOUTHETN MARYLAND HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 A M 2 D F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours TRINIDAD Director 78 579-68-5889 Yrs. 193 APRIL 20 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S TEMPLE HILLS 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3608 DIXON STREET 20748 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: BLACK 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MASTER ELECTRICIAN PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **EDWARD** MELVINA PAUL PENERA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10218 CHERVIL COURT MANASSAS, VIRGINIA TUJUANNA MAYO/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) RESURRECTION CEMETERY 8/28/2010 CLINTON, MARYLAND 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, each global in model of cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? s been signed by the atte should be detached for Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE RENAL 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performe 1 Yes 2X No Yes 2 No 25. Was case referred to dical funeral director. Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Tes မ 1 Inpatient ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 L Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) REDIDY, 29b. Signature and title of certifier TARAK 29d. Date signed (Month, Day, Year)

CR 2

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

AUG 3 0 2010

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year Physician/ August 21, 1:30 Virginia Foreman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Encore at Turf Valley Ellicott City Howard Social Security Number If Under Year If Under 24 Hrs. g. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🏻 F Feb. 14, 1916 Maryland Months Hours Director 577-12-5958 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Columbia Maryland Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 212 - 8610 Snowden River Parkway 21045 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nettie Brooks John Skinner 19a. Informant's Name/Relationship (Type, Print)
Cecelia M. Routh/ Daughter 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) # 212-8610 Snowden River Parkway Columbia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State August 2010 30, Suitland, Maryland 4 Donation 5 Other (Specify) Signalure of Funeral 3, rvice Licenses 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RON ARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DENENTIA END STAGE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

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GUPTA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death August 20 Day 2010 Year Physician/ 1:20 A M Lee Felder Mary Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner Prince George's District Heights Forestville Health & Rehabilitation If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup>1924 1 🗆 M 2 🔀 F March 13, South Carolina 248-76-0819 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Forestville 1 X Yes 2 No Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 20747 United States 7420 Marlboro Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ **Black** Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Private Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဨ Mallard Elease Willie Mallard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Washington, DC 20032 4412 3rd Street SE Apt #C Alice D. Felder/ GrandDaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 28, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln 2010 Brentwood, Maryland ture of Funeral Service Licer 22 Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardio Pulmonary Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Stroke left Hemiplegia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No has certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 2 🛂 No s after death.

I Director: After this contained in by the funeral dire 1 Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 4 Homicide determined

within 24 hours a

To the Funeral C

completed filled

Bahram Pishdad, M.D. 31. Date filed (Month, Day, Year) AUG 3 0 2010 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328 Southern Ave. SE Washington, DC

Medical

29a. Certifier

only one

29b. Signature and

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D51520

29c. License number

29d. Date signed (Month, Day, Year)

08-23-2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 2010 32 Registrar's Signature			シードンし				0	.C.M.E.			September	1, 2010	)
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28627 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Irene E. Granger 2010 0658 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Elkton Care and Rehabilitation E1kton Ceci1 8. Date of Birth (Month, Day, OCT 23, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthdav) 9. Birthplace (State or Foreign Months Days Hours Min. <sup>Year)</sup> 1931 1 □ M 2 🗓 F 78 502-30-0058 North Dakota Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 481 Elk Mills Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joe Sarkinen Flora Muonio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flora E. Treut/Daughter 3503 Telegraph Road, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bay View Cemetery 3, 2010 Bay View, MD 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FIBNIUCI TRIAT disease or condition resulting in death) Due to (or as a consequence of): STEPSI Sequentially list conditions, if any leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a cursoquence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPEMENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only o re) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Department of Important: If it any Injury or conce.

**Physician** 

/Medical

Examiner

uneral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatith and Mental Hygiene.
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Baltimore, Maryland 21215-0036

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Director

Funeral

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Completed

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Physician/Medical Examiner physician and s the burial-tran attending pl certificate has been signed by the rector, page 2 should be detached 3 Completed funeral director. Be Certification: To After this

Division of Vital Records, P.O. Box 68760

4 Homicide

29a. Certifier (Check only one)

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number P. v. Neys 100 65733

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. V. PULA Street EHIGH 126

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Andrew Joseph Go	-	o S1 - For State	tate of Maryl	and / [	•	nent of cate of		l Menta	l Hygi		) N-		
Physician		l <mark>egistrar</mark> 1. Decedent's Name (First, Midd	lle,Last)	-		-				Date of Dea		201	J. Time of Death 2
Medical Examine	er	Andrew Jose							A	Month Jugust 3			1520 hrs
	1	4a. Facility Name (if not institution St.Mary's Hospital El	· <del>-</del>	umber)		4	b. City, Town, or I Leonardtowr		eath)			County of Deat :. Mary's	h
Farmeral	4	5. Social Security Number	6. Sex	7 Age (1	n yrs, last b	irthday)	If Under 1 Year	If Under 2	4Hrs. 8.	Date of Bi			rthplace (State or
Funeral Director			1 X M 2 F	· · · · · · · · · · ·	23	Yrs.	Months Days	Hours	Min.		·	Forei	
	-	161-70-9634 Usual Residence of Decedent	I W Z F	L	23	115.				01/14	/198/	/ Per	insyivania
any		10a. State 10b. County		10	c. Cify, Tow	n or Location	on						10d. Inside City Limits
and Fshow	5 1	Maryland St. Ma	ary's_	L	eonar	dtown		<u></u>					1 Yes 2 No
the Marylanc a or 28a-f sh tified at onc	2	10e. Street and Number					10f. Zip Code			1	10g. Citize	en of What Cou	intry?
tith the Maryland 23a or 28a-f show notified at once.		43509 Deer Rus	n Court	and and Five	II C	142 18/2	20650 Decedent of Hisp	ania Osinia	2 / Specif	. Ves es No		ted Sta	tes ican Indian, Black,
r death with , or items 23	<u> </u>	1 Never Married 2 M	larried Armed F	forces?			s, specify Cuban,				'   '	White, etc.	ican indian, black,
fler de		3 Widowed 4 Div	1 Yes	2 X ar	l No	1	Yes 2X No	specify:			s	Specify: W	hite
ours aftual" xamine		15. Decedent's Education (Spe	or Dates: ecify only highest gra	de comple	eted) 16a		s Usual Occupations of working life.			done	16b. Kii	nd of Business	
0036 within 72 hour giene. her than "natu Medical Exar		Elementary/Secondary (0-12)		1-4 or 5+)				00 110 1 40	o . o				
-003 l withi giene.	<u> </u>	17. Father's Name (First, Middle		5	S	tuden		8.Mother's N	lame (Fir	st. Middle.		Llege	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	7	Ivan John Goyco						Joan (	•			,	
ould b d Men s mark		19a. Informant's Name/Relations			11	9b. Mailing	Address (Street					or Town, State	e, Zip Code)
MD id 2 sho ulth and m 27 is aumat		Joan Goyco/Moth	ner				Deer Ru						20650
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Finneral Director	- 11.7	20a. Method of Disposition  1 X Burial 2 Cremation	n 3 Removalf	rom State		atory or other	ion (Name of cem er place)	etery,	Da	ite	20c. Lc	ocation - City or	Town, State
Baltimore, bernit. Pages I an Department of He important: If ite		4 Donation 5 Other S	pecify:		St. I	Denis	Cemetery	, O	9/09/	2010	Hav	ertown,	PA
Bal permi Depar Impo		CMUNION			0050	22. Na	TE TI 11	B	rins	field	Fun	eral Ho	ome, P.A.
Physician		3a. Part I. Enter the disease, or	complications that	r. MO		229	JO HOTT	WOOd	Roau	• Leo	$\mathbf{n}$ aru	LOWILLE	Approximate Interval
/Medital(		failure. List only one cause Immediate Cause (Final disease	Aanl	hyxia									Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as	a consequ	ence of):								
	5	Sequentially list conditions, fany, leading to immediate	b. Due to (or as	a consequ	ence of):								-
led Insit		cause. Enter Underlying Cause	C										
H ted	LYB	events resulting in death) Last	Due to (or as a	a consequ	ence of):								
OX 68760, eath certificate be executed attending physician and for use as the burial - transit ssician/Medical Ex	<u> </u>	UNPENDED	X AMENDED	23a	27,2	8a-f	Pep 17e 28	907.19-	16-1	0 vt	·		
760, cate be physic he bur		F FEMALE:			of pregnanc		<u> </u>	/-IIV			23d.	Date of deliver	у
K 6876( n certificate ending phy use as the b	<u> </u>	3b. Was decedent pregnant in the past 12 months?	I I LIVE		e of death		Ideath 3 (	_Ectopic pr	egnancy		N	Month	Day Year
Box 6 e death cer the attendi	ōŀ	1 Yes 2 No 9 Uni	'			5 Uth	er (Specify)				30		
d by D		Part II. Other significant condit	ions contributing t	to death bu	ut not resulti	ing in the un	derlying cause gi	ven in Part I		_		_	the cause of death?
S, P uires th an signe d be d													bably 4 Unknown
cords, Law requir has been s	2						. =		_	24a. Was autop			utopsy findings available completion of cause of
Division of Vital Records, tall or Attending Physician: The law requirer and restret death. There has been signed in by the funeral director, page 2 should be entitication: To Be Completed	<u>.</u>				_					1 Yes	2 ✓ No	1 \( \) Y	es 2 No
Ital Recidin: The Confictor, page		25. Was case referred to medica examiner?		Inpatient	0.4.50	Outpatient	- Ic	of Death (Ch	ursing Ho		Residence	ce 6 Othe	
1 of Villing Physic Ling Physic Ling Physic Ling Physic Ling Ling Ling Ling Ling Ling Ling Ling	. 1	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	of Injury		. Time of Inj	v	at Work?	28d	Describe	how injun	v occurred	
Sion ( Attending death. Ctor: Af	3	1 Natural 5 Pend	ding (Mont	h, Day,Year)		2:34	1 Y	es 2 X No		ubjec <del>inkno</del> v		phyxia	ted self
VISION Afturence or Afturence or Afturence or Afturence or Afturence or Afturence or Affuce or A	3	. 😾					, factory, office bu	ilding, etc.		-		d Number or Ru	ural Route Number, City er Run Ct.
Division c Hospital or Attending 24 hours after death. Reneral Director: A redy filled in by the fun		4 Homicide dete	rmined (Specify,	) 1	reside	ence			Le	onar	dtown	St. M	ary's Co.,Md
Divis To the Hospital or 4 within 24 hours after To the Funeral Dire completely filled in be			hysician: To the be miner:On the basis										
To the Ho within 24 To the Fu complete!		29b. Signature and title of certific	and manner:		attort androi	mvootigatio	29c. License					ate signed (Mo	
	-	( 10 1. 1.	NA				O.C.N					ember 1, 20	
	3	30. Name and address of person	who completed cau	ise of deat	h (Item 23a)	)					1		
	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
State Registra		31. Date filed (Month, Day, Year)	2010 32 R	egistrar's	47	par	W						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Edward G. Gray, Jr. 2010 9:03 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County E1kton Cecil 8. Date of Birth (Month, Day, Year) June 8.1926 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 1 XXM 2 □ Hours Director 414-28-3483 84 Tennessee Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Cecil Perryville 10e. Street and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral 591 Mountain Hill Road 21903 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? 1XXYes 2 ☐ No Black, White, etc 1 Never Married 2 XMarried ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates. 1942-50 if Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Medical R 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Minister Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward G. Gray, Sr. Elizabeth Goans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Resa B. Laird / Daughter 112 Revelation Drive, North East, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) 31, August Principio Cemetery Perryville, Maryland 21. Signature of Fu 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ospital or Attending Physician: The law requires that the death certificate be thours after death.

Inneral Director: After this certificate has been signed by the attending physicia filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ao 24a, Was an 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral E Medical 29a. Certifier Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

44 IVA

State Registrar 31. Date filed (Month, Day, Year) SEP 0 1 2010

30. Name and address of p

32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Mar				Mental Hy		00.		_
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	<i>Death</i>	2. Date of De	Reg. No	401	0	28530
	Physicia		Marian G	mens				2. Date of De	28 Da	boll	ear 3	21:10 M
	Medic Examin		4a. Facility Name (if not institution, give st	treet and number)		4b. City, Town, or	Location of Death			. County of	Death	
- 1			11540 Jamestown Ct			Laurel	Livii - Odii			ward		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (/ 68	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da 12-24-1	rth ay, Year)	т.	3. Birthpl Co <i>unti</i> Lber	lace (State or Foreign
			213-62-8301 Usual Residence of Decedent	1 00				11 2-24-	941		LDEL	ıa
	fland f shored ad at	tor	10a. State 10b. County	1	Oc. City, Town or Lo	cation					10	0d. Inside City Limits
	e Mar r 28a- notifii	)ire	MD Howard  10e. Street and Number	] ]	Laurel	10f. Zip Code			10 0	tizen of Wh		1XX Yes 2 No
	vith th	ral	11540 Jamestown Ct			20723				LIZEII OI VVII	at Couri	Ty:
	tems	Funeral Director		12. Was Decedent Eve	r in U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	USA	14. Race -		
3-003p	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The Health and Mental Hygiene.  The Maryland Salary and Salary a	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		f Yes, specify Cuba I ☐ Yes 2 🛣 No		Rican, etc.)		Specify.1	White, e	tc.
o O	2 hou "natu edical	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done o	ation Juring most of work	king	16b. K	Kind of Busi	ness Ind	ustry
717	ithin 7 ene. • than he Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)	Domest	O NOT use retired)			Priv	vate		
<u> </u>	lled w other other rent, t	Be	17. Father's Name (First, Middle, Last)		LOMES	-10	18. Mother's Nan	ne (First, Middle	Maiden	Surname)		
yland	d be f Menta arked atic ev	욘	Charles Cooper				Maryann 3	Johnson				
Nar Nar	shoul and is m raum		19a. Informant's Name/Relationship (Typ			ng Address (Street a					e, Zip C	ode)
ຍົ	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.	- 1	Willie Givens/Husba	ina	20b. Place of Dispo	Jamestov		Date	1	ocation - C	ity or Toy	wn. State
baltilmor	age 1 ent of nt: If ii y or c		1 ☑XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crer Sates of H	natory or other place	e)				•	
	permit. P Departm Importai any injui		21. Signature of Funeral Service License		A A 22	2. Name and Address	ss of Facility Ron	ald Tay	lor	II Fu	nera	al Home
٥			Thanks //	FAM		8 W. Nort				D 212	01	
			23a Part 1 Enter the disease, or compli	cations that caused the cause a each line.	e death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
P	h sician/ Medical	0.3	Immediate Cause (Final disease or condition resulting in death)	Chol		CAVCCA	anna				-	Onset and Beaut
_	Examiner			Due to (or as a c	onsequence n:							
		iner	Sequentially list conditions, cause. Enter Underlying	Due to or as a c	onsuguence of):							
	cuted ind transit	xam	that initiated events	Due to (or as a c							_	
	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) Last	. Due to (or as a c	onsequence or,							
8	cate t p phys s the l			d								
90	ending use a	an/N	23b. Was decedent pregnant	3c. If yes, outcome of	pregnancy Fetal death 3	Ectopic pregnanc	ev.			23d. Date	of delive	*
. DOX	ne death y the atte	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ♠No 9 ☐ Unknown	4 Pregnant at ti 9 Unknown		Other (specify)				Monti	ר	Day Year
r.	that the	by P	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	ınderlying cause giv	en in Part I.					e cause of death?
g.	equires sen sig ould b	ted						1 🗆	Yes 2			pably 4 Unknown
Hecords,	law re has be e 2 sh	Completed						24a. Was		pric	re autop or to con ath?	psy findings available inpletion of cause of
֝֝֟֝֝֟֝֝֝֝֝֟֝	The ficate r, pag		25. Was case referred to medical			20. 51	(D. II. (O)	1 🗌 Yes		lo 1 [	Yes	2 X No
VItal	s certif	To Be	eyaminer?	lospital:	2 ER/Outpatier	Oth	ace of Death (Checer er: 4  Nursing H		idence (	6 Other	(Specify)	
ō	ig Phy ter this neral o		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	28b. Time of		/ at	28d. Describe				
0	tendir leath. tor: Af the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 □	Yes 2 ☐ No		_			
DIVISION	tal or Atra safter of all Directed in by		4  Homicide determined	building, etc. (	- At home, farm, str Specify)	eet, factory, office		28f. Location ( City or To			or Rural	Route Number,
	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death.  within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check conly one) 1 Certifying Physic Check conly one) 2 Medical Examina only one) 3 Certifying Nurse	er: On the basis of exai	mination and/or inves	tigation, in my opinio	on, death occurred a	at the time, date	and place	e, and due to	the cau	use(s) and manner stated.
	To t To t		29b. Signature and title of certifier			29c. License	o 4261		29d. Da	ate signed (	Month, D	Jay, Year)
2	5		30. Name and addless of person who co	mpleted cause of dea	th (Item 23a) (Type, F	COUN.	Blud.	Elde	Sbv	VK.1	NO	21784
	Stat Registra		31. Date filed (Month, Day, Year) AUG 3 1 2010	32. Registrar's	Signature	)				9		

		For State Registrar		marylar 			of Death	nd Mental H	Reg. No	2010	28631
Physicia /Medica	-	Decedent's Name (First, Middle, La     William Pau	1 Gard					2. Date of Month August	. Da	3, 2010	3. Time of Death 5:30 P
Examine Funeral		4a. Facility Name (If not institution, giv  Charles County No.  5. Social Security Number 6. S	ursing Ho	ome	last birthday)	La If Under 1		24 Hrs. 8. Date of I		Charles 9. Birthy	S  place (State or Foreigntry)
Director		214-18-8442  Usual Residence of Decedent  10a. State 10b. County	X M 2□F	92	Yrs.		ays Hours	February	7 28,	1918 Ma	aryland  10d. Inside City Limits
ith the Marylan or 28a-f ehow se notifited at	rector	MD Charle  100. Street and Number	es		La Pla		ode		10g. Ci	itizen of What Cou	1X Yes 2 □ No
72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow dical Examiner must be notified at	/ Funeral Director	310 Spruce Street  11. Marital Status	12. Was Deced Armed Forc 1 2 Yes 2 If Yes, Give	es? ∐No		Was Deceden		gin? (Specify Yes or Puerto Rican, etc.)	No-	USA  14. Race - Amerin Black, White,	
vithin 72 hours ne. han "natural", e Medical Exe	Completed by	3 Widowed 4 Divorced  15. Decedent's E. (Specify only highest grade)  Elementary/Secondary (0-12)	Year or Date	es:	16a. Dece (Give life.	dent's Usual C kind of work of DO NOT use i	Occupation done during most retired)			Kind of Business/In	
buid be filed w Mental Hygier arked other ti atic event, the	To Be Cor	17. Father's Name (First, Middle, Last, George I. Gardine			VP	Branch		r 's Name <i>(First, Midd</i> ia Theresa	ile, Maidei	-	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehov any injury or other traumatic event, the Madical Examinar must be notified at once.		19a. Informant's Name/Relationship (  Joseph Gardiner,  20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □	Jr./Nephe	20b.	P.O.	Box 9	99, La I	Plata, MD 2 Date 0/3/2010	20646 20c. L	or Town, State, Zij	own, State
permit. Pe Departmen Important any injury once.			Chola	190945	2	AREHAR 211 St	TECHOLS . Mary's	S FUNERAL S Ave. La	HOME Plata	,P.A.	
	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	as a consect	quence of):			lerosi			Interval Between Onset and Death
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		h 2 Fet	aldeath 3	]Ectopic pregi ] Other <i>(speci</i>				23d. Date of deliv Month	rery Day Year
w requires that the bean signed by should be detac	à	Part II. Other significant conditions of	contributing to dea	th but not re	sulting in the u	nderlying caus	se given in Part I.			use contribute to	the cause of death?
	Completed							pe 1 ☐ Ye	topsy informed? s 2√2 N	death?	opsy findings available ompletion of cause of 2 No
nysician: T	io Be	25. Was case referred to medical examiner?	Hospital: 1   Ing	patient 2	] ER/Outpatie	nt 3 DOA	,	of Death (Check on rsing Home 5 🗆 R		6 ☐Other (Speci	rfy)
ng Pl	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio 3 Suicide 4 Homicide Getermined	e 28e. Place o		28b. Time o Injury	М	Injury at Work? 1 Yes 2 N	28d. Descrit No 28f. Location	e how inju	ury occurred  and Number or Rur	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Cartifier (Check only one)  1 Certifying Ph	nysician: To the b miner: On the bas and manne	is of examin	owledge, deat ation and/or in	h occurred at vestigation, in	the time, date and my opinion, deat	d place, and due to the time	he cause(: ie, date ar	s) and manner as and place, and due to	stated. to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	- //	10			icense number	55	29d. D.	ate signed (Month,	, <sup>Деу, Үеаг)</sup>
BB 841 Stat	е	30. Name and address of person who Fatima Hussein, M 31. Date filed (Month, Cax, Year)	D 5625 A		own Roa		te 101,0	Camp Sprin	gs,MI	20746	

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 September William B.D. Harris Jr 7:30 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 5632 Poole Road Jefferson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Pennsylvania 197-01-8097 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If tiem 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10c. City. Town or Location 10d. Inside City Limits Completed by Funeral Director Frederick Jefferson MD 1 Tes 2 No 10g. Citizen of What Country? Poole Road U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ¥ Widowed 4 □ Divorced If Yes, Give Year or Dates Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer *Aerospace* To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margurite Lukins William B.D. Harris Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 Old Middletown Rd. Jefferson, Md. 21755 Maureen Norman (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) years Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No Yes 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 - Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at al Director: After the funeral 1 Natural 5 Pending work? within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

cause of death (Item 23a) (Type, Print)

Frederick

Blvd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Date C Month Physician/ Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GEORGE OUTHERN MARYLAND 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Hours Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits GEORGES 10c. City, Town or Location Funeral Director HEIGHTS DISTRICT 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 YNo 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FOOD ABEVERAGE DIZH WASHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ UNKNOWN KNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8234 · GERMANTOWN MD. 20874 WILLIAM ZON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Place of Disposition process cemetery, crematory or other p Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 128/10 FREDERICK, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER 21. Signature of Funeral Service Licenses Phillips ST. WOODBRIDGE 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final UXI Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ere or rovas ar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ension Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as be nsequence of) Physician/Medical 8 Dm Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 2 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death Other (specify) signed by the a d be detached for Part II. **Other significant con∜iti<u>o</u>ns** contributing to death but not resulting i**∫**the underlyi∱g cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: ည 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cellifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title person who completed cause of death (Item 23a) (Type, Print) 30. Name and 32. Registrar

DHMH 17 Rev 7/2009

State

Registrar

AUG 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ DA חנטכ :35 Garfield, Robert Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9104 Constantine Drive Prince Georges Washington Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 🗙 M 2 🗆 F Days Min. Director 579-48-5474 rgini Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Examiner must be notified at Director 28a-f 1 Yes 2 No Prince Georges Ft. Washington 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9104 Constantine Drive 20744 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . 0 Completed by 1 Never Married 2 🙀 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black "natural", 3 - Widowed 4 - Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 75 Sexton Church Caretaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ t. Page 1 and 2 should be trment of Health and Mer Sidney Jackson Odessa Moats 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ophelia O. Hooks-niece 9104 Constantine Drive, Ft. Washington, MD 20744 t: If item 2 or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cem D8-27-2010| Triangle, VA 22. Name and Address of Facility Strickland Funeral Services . Signa ure of Funeral Serv 6500 Allentown Road, Camp Springs, MD 20748 23a. Pat. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Opset and Death years Physician/ Cancer Of the Tongue disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 😾 Residence 6 🗆 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 Yes 2 No Investigation **Director:** 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medica xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifyin Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce se number 29d. Date signed (Month. Day, Year) D41728 08-24-2010

Registrar
DHMH 17 Rev 7/2009

State

1400 Forest Glen Rd. suite 435, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Patrick Cross M.D. 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 28636 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 2044 Milton Kucharczyk Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** WMHS= Regional medical Center Cumberland Allegan Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 4 1934 Funeral 1 XM 2 🗆 F Director 216-30-5870 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Sa or 28a-f sh be notified MD Frostburg Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a ( must be 21532 100 Honeysuckle Lane U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates Health and Mental Hygiene. em 27 is marked other than "natur ther traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Companies Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Kucharczyk Martha Barkowski Kucharczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Washington Street Frostburg, MD 21532 Jim Kucharczyk Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 9-7-2010 Frostburg Mem Park Frostburg. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Frostburg, 311 Alan 60 W. Main St. Somers 100547 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Dualto (or as a sonsequence of, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Kidary Records, 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 1 ☐ Yes 2 ☐ No Division of Vital funeral director. Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No ဂ္ 1 Impatient 2 🗆 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Peath 28b. Time of ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No М Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

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completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title certifier 10 55 th (Item 23a) (Type, Print)

Registrar

State

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8/19/2010 3:40am<sup>M</sup> Hazel Rececca Taylor Knipfer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Envoy of Denton Nursing Home Denton Caroline If Under 1 If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2/5 F 86 213-14-4031 Director Md 3/11/1924 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 🏋No Director Caroline Greensboro MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 21639 USA ns 23a o 26351 Stallings Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or items idical Examiner mu Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes **2** X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify: White Specify. þ XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Meat Wrapper Acme Food Stores lith and Mental Hygiel 27 Is marked other the r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Franklin Taylor Eleanor Ireland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Karen L. Patrick Daughter 26351 Stallings Rd. Greensboro, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or c 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Denation 5 □ Other (Specify) 8/23/2010 West River, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Sign (Ure of Funer & Service Lice Lee 12 Ridgely Ave. Annapolis, MD 21401 23a Part1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or hear if fillure. List only one cause on each line. Approximate Interval Between Onset and Death nr diate Cause rigal se or condition Iting in death Physician ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any many transfer in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physlclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician at the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ပ 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No I hours after death.

'uneral Director: A

sly filled in by the fu 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0047534 Wafik Ibrahim Zaki 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Denton MD 21629 Street Marke Month, Day, Year) AUG 2 5 2010 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryl	-	artment of F <i>tificate of L</i>			ene 2 0 1 0	28638
	Dharisis	,	Decedent's Name (First, Middle	, Last)		imouto or z	704.7	2. Date of Death	Davi Vaan	3. Time of Death
	Physicia Medic	al		Anthony Kane				August	23,201	
	Examin	er	4a. Facility Name (if not institution,  Doctor†s	Hospital		4b. City, Town, or	Lanham	Ū	4c. County of Dear	
	Funeral		5. Social Security Number		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	g Bir	thplace (State or Foreign
	Director	20	578-70-9707 Usual Residence of Decedent		57 Yrs.			Jan. 30,	1953	DC
	yland -f shov ed at	ctor	10a. State 10b. County	_	City, Town or Loc					10d. Inside City Limits
	ne Mar or 28a	۵	Maryland   Prince	e George's		N 10f. Zip Code	lew Carrol		Og. Citizen of What Co	1 🖾 Yes 2 🗆 No
	s 23a o	Funeral	7615 Riverdale	Road Apt # 130	0		20784		-	States
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🍱 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🗷 No	ispanic Origin? (Spe In, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
15-	72 hoi n "nat Aedica	Completed	(Specify only highe	t's Education st grade completed)	(Give k	ent's Usual Occup kind of work done of O NOT use retired)	ation during most of worki	ing	6b. Kind of Business	Industry
272	within rgiene. ner tha t, the l		Elementary/Seconday (0-12)	College (1-4 or 5+)	I		Operator	<u> </u>	Pri	vate
9-9- and 2	ntal Hy red oth	To Be	17. Father's Name (First, Middle, L	<sup>ast)</sup> Liam Stewart			18. Mother's Name	e (First, Middle, Ma Villnette	aiden Surname) e White	
aryl	hould than the second than the		19a. Informant's Name/Relationsh		19b. Mailin	g Address (Street a	and Number or Rura	al Route Number, (	Dity or Town, State, Zi	p Code)
<i>a</i> ) €.	and 2 s Health a mm 27 i		Tia Kane/ Daug							Md. 20901
Kane Itimore, 1	Page 1 sent of Hent of Hent of Hent of Hent of Hent of Hent or ot		20a. Method of Disposition 1	3 Removal from State	-	sition (Name of natory or other plac Olivet		st 27,	Oc. Location - City or  Washingto	
Kane, Leon Baltimore, Maryland 21215-0036	permit. Page 1 and Department of half Important: If its any injury or ot once.		21. Signature of Funeral Service L		TA 1 22	. Name and Addres	ss of Facility Ste	ewart Fur	neral Home	, Inc.
			23a. Part 1 Emer the disease, or	complications that caused the d			_			Approximate
7	Physician/	61.4	shock, or fleart failure. List o Immediate Cause (Final disease or condition		es of	Li	ier			Interval Between Onset and Death
7	Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
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260	te be e hysicia he buri	edical		d						
687	eath certifica attending pl		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	gnancy				23d. Date of de	slivan (
). Box 68	or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Ectopic pregnand Other (specify)	,		Month	Day Year
'ds, P.O.	requires that the des been signed by the should be detached	by	Part II. Other significant condition	ns contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.		acco use contribute to	o the cause of death?
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/ital	rsician s certifi lirector	To Be	25. Was case referred to medical examiner?  1  Yes 2	Hospital:	☐ ER/Qutpatien	Oth	er:		ice 6 🗆 Other (Spec	nife)
on of \	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to proper the funeral director, page 2 to page 2.		27, Manner of Death  1 Natural 5 Pendin 2 Accident Investig	28a. Date of injury (Month, Day, Year	28b. Time of	28c, Injun work	y at	28d. Describe how		
Divisio	al or Atte s after de al Directo ed in by th		3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi			et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical E	Physician: To the best of my kn xaminer: On the basis of examina Nurse Practioner: To the best of	ation and/or invest	igation, in my opinio	on, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	To ti with To ti		29b. Signature and title of certifier			29c. License	the state of the s		d. Date signed (Mont	
1	- (n		30. Name and address of person v	who completed cause of death (I	tem 23a) (Type, P	rint)	7	/ / 4.	-1 1	90
U19	Stat	e	30. Name and address of person v  THOINAS M. HA  31. Date filed (Month, Day, Year)  AUG 3 0 2010	32. Registrar's Sig	mature .	res Luc	OK KUAS	5 LAR	- not , 110	30706
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Joseph Michael Kennedy

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dical Examine			el Kennedy			- I 41	b. City, Town, or	Location		August 2		c. County o	f Death	1556 hrs	_
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Funeral	5. Social Security No	umber	6. Sex	7, Age (In yrs.	last birthda	y)	If Under 1 Year			8. Date of B	rth(MM	/DD/YYYY	9. Birt	hplace (State or Washington	_
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ryland a-f show	Maryland  10e. Street and Num	Calver	<u> </u>		Owi	igs T	10f. Zip Code				10a Cit	izen of Wh	at Coun		_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Bo Completed by Ermoral Disortor	1021 Lord		Drive					0736			•	nited S		•	
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B35	Mary G. Ripp		Deputy Chief			111	Penn Street,	Baltim	ore, MC	21201					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 30 per DVR G907 9/13/10 dk. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) A44457 2:05 PM **Physician** 20/0 Nancy Jean Knott 3/ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Western Maryland Hospital Center Hagerstown Washington Birthplace (State or Foreign Country) Under 24 Hrs. | 8. Date of Birth Hours | Min. (Month, Day, Year) Year If Unuc last birthday) If Under 5. Social Security Number . Age (In yrs. **Funeral** Days 1□M 2□F Months Yrs. 76 Director May 8,1934 Pennsylvania 186-28-9171 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 ☐ Yes 2 No 28a-f sh notified WV. Berkeley Falling Waters Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 25419 435 River Bend Park P.O. Box 413 U.S.APages 1 and 2 should be filed within 72 hours after death winent of Health and Mental Hygiene.
ant; If Item 27 Is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must t. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Groomer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Esther R. Knott Richard Knott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tra 149 Snyders Lane Martinsburg, WV. 25405 Patricia Alexander (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 3, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home MO1414 wis Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on cach line. PIRATORY HAIL YNE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due te-(or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cart burial-trar Due to (or as a consequence of) physician a 파기수 교통 기식 기식 기업 기업 기업 기업 Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months?

1 Yes 2 No
9 Nonknown 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by COPD 1 Yes 2 No 3 Probably 4 Whiknown page 2 should desorder 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Ch. descan certificate ! Anemia 1☑ Yes 2□ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manne of Death 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0064911 08/3//10 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue Dr Muhammad Abdullah Hagerstown, MD 21742 31. Date filed (Month, Day, Year) 32. Registrar's Signature State for SEP 13 2010 Registrar DHMH 17 Rev 1/2001

DHMH 17 He

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Mitral Insufficiency  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Coronary Artery Disease  Bushing in death)  The past 12 months?  In the	once.	$\Lambda$									
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Due to (or as a consequence of):  Congestive Heart Failure  Loud for as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Renal Failure  23d. Date of delivery Month Day Yo  Due to (or as a consequence of):  Coronary Artery Disease  Date of delivery Month Day Yo  Date of delivery Month Day Yo  Due to (or as a consequence of):  Coronary Artery Disease  Date of delivery Month Day Yo  Does delive	1/	Immediate Cause (Final	ficionov					Interval Between Onset and Death			
Congestive Heart Failure	al		liciency								
Renal Failure		Sequentially list conditions,	Construction of the Constr				eart Failure				
Renal Failure	J ig	cause. Enter Underlying Cause (Disease or iinjury	erv Disease								
25. Was case referred to medical examiner?  27. Manner of Death  28. Date of injury  28. Date of injury  29. Date of obacco use contribute to the cause of death?  29. Date of Death (Check only one)  27. Manner of Death  28. Date of injury  28. Date of injury  28. Date of Death (Check only one)  27. Manner of Death  28. Date of injury  28. Date of injury  28. Date of Death (Check only one)  28. Date of injury  28. Date of Death (Check only one)  28. Date of injury  28. Date of Death (Check only one)  28. Date of Injury at work?  1   Yes 2   No  29. Date of Death (Check only one)  28. Date of Injury at work?  1   Yes 2   No  29. Date of Death (Check only one)  29. Date of			Due to (or as a co								
25. Was case referred to medical examiner?  27. Manner of Death  28. Date of injury  28. Date of injury  29. Date of obacco use contribute to the cause of death?  29. Date of Death (Check only one)  27. Manner of Death  28. Date of injury  28. Date of injury  28. Date of Death (Check only one)  27. Manner of Death  28. Date of injury  28. Date of injury  28. Date of Death (Check only one)  28. Date of injury  28. Date of Death (Check only one)  28. Date of injury  28. Date of Death (Check only one)  28. Date of Injury at work?  1   Yes 2   No  29. Date of Death (Check only one)  28. Date of Injury at work?  1   Yes 2   No  29. Date of Death (Check only one)  29. Date of	edica	Renal Failure									
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25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 2   EP/Outpatient 3   DOA  28a. Date of injury At work? 2   Accident 4   Homicide  28a. Date of injury   28b. Time of injury   28c. Injury at work? 3   Suicide 4   Homicide  28a. Date of injury   28b. Time of injury   28c. Injury at work? 4   Homicide  28a. Describe how injury occurred  28b. Place of Injury - At home, farm, street, factory, office  28c. Injury at work? 1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how inj		Part II. Other significant condition	is contributing to death but no	underlying cause gi	ven in Part I.		23e. Did tobacco use contribute to the cause of deat				
25. Was case referred to medical examiner?	eted										
25. Was case referred to medical examiner?	omp						auto perfe	psy ormed?	prior to c death?	ompletion of cause of	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lowell F. Satler MD 110 Irving St., NW Suite 4B-1 Washington DC 200  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		examiner?	Hoopitals				ck only one)				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lowell F. Satler MD 110 Irving St., NW Suite 4B-1 Washington DC 200  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		1.7	1 Inpatient		ent 3 LI DOA	4 ☐ Nursing F				fy)	
29a. Certifier (Check only one) 3	ficate	1X Natural 5 ☐ Pending 2 ☐ Accident Investiga	worl	work?							
29b. Signated and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lowell F. Satler MD 110 Irving St., NW Suite 4B-1 Washington DC 200  131. Date filed (Month, Day, Year)  32. Registrar's Signature											
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  D0033256  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lowell F. Satler MD 110 Irving St., NW Suite 4B-1 Washington DC 200  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Aedica	(Check 2 Medical Ex	stigation, in my opini	gation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mann							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lowell F. Satler MD 110 Irving St., NW Suite 4B-1 Washington DC 200  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	-					29d. Date signed (Month, Day, Year)					
Lowell F. Satler MD 110 Irving St., NW Suite 4R-1 Washington DC 200  31. Date filed (Month, Day, Year) 32. Registrar's Signature		30. Name and address of pares ::						8-24-10			
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Lowell F. Sat	ler MD 110	Irving	· ·	Suite	4R-1 Wa	ashing	ton	DC 20010	
	tate trar	31. Date filed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )  NOV 1 2 2010	32. Registrar's S	Signature							

			For State Registrar	State of	of Marylar	nd / Depa <i>Cer</i>	artment of F rtificate of	lealth and <i>Death</i>	i Mental Hy	/gienę Reg. No.		286	42	
*		1. Decedent's Name (First, Middle, Last)  Physician /Medical  Ruth Weaver Messimer							2. Date of D Month Augus	Day		3. Time of E	Death P M	
	Examin		4a. Facility Name (If not institution, gi	a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death			
<u></u>			Caraway Manor As 5. Social Security Number 6.	ssisted Sex	Living	lact hirthday)	E1kto		rs. 8. Date of B	irth	Cecil	place (State or	Foreign	
	Funeral Director			1 ☐ M 2 🖁 F	89	Yrs.	Months Days	Hours M		ay, Year)	Cou	rvland	roreign	
	pu ,		Usual Residence of Decedent			ty, Town or Lo	ontion		, , , , , ,	, 1,2			Limita	
larviar	faryla show ed at	or	10a. State 10b. County			_	cation					10d. Inside City 1 ☐ Yes	-	
	the N 28a-1 notifi	Director	Maryland   Cecil	E1kton					izen of What Cou	ntry?				
	th with		45 Horizon Lane				21921				United States			
9	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	Armed F	cedent Ever in Uorces? 2 No ive	'	Was Decedent of F f Yes, specify Cub	an, Mexican, Pu	(Specity Yes or Nerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: T.11			
5-0036	ural",	d by	3 Midowed 4 □ Divorced						White					
,	within 72 l ene. than "nat h. Medica	Completed	15. Decedent's I	(Give	edent's Usual Occupation  e kind of work done during most of working  DO NOT use retired)				16b. Kind of Business/Industry					
7 7	d with giene.	mo.	Elementary/Secondary (0-12)	College	(1-4or 5+)	Не	ad Telle	r		<u> </u>	Banking			
land	be filed and and and and and and attention of a their event, the	Be	17. Father's Name (First, Middle, Las	it)					lame (First, Middle		Surname)			
_	should and Men	욘	George Weaver  19a, Informant's Name/Relationship	(Time Chief)		40h Mailin	ng Address (Street		ie Jewell		Town Chair 7	n Cadal		
Mar	nd 2 sh Ith and 27 is n traun		Naomi Thomas/Dat				orizon La			219 219		) Code)		
ē,	es 1 and 2 should bot Health and Ment I tem 27 is markec rother traumatic er		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of	1	Date tember		ocation - City or T	own, State		
altimore,	Pages ment of ant: If It ury or o		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		<sup>n State</sup>   Gi   Me	lpin Ma morial	natory or other pla anor Park	1,	2010		Elkton,	MD		
gall	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service Lice	ensee	Α	22	2. Name and Addre		Hicks Ho					
	20 = 8 O	A. 15	23a. Part1. Enter the disease, or co	mnlications that	caused the dea	th. Do not ent			on Street		kton, MD	21921 Approximate		
	Physician		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on	each lìne.		dive L	_				Interval Betw Onset and Do UMKNO	eath	
7	/Medical Examiner		1	Due to	(or as a conse	quence of):								
		ner	Sequentially list conditions, if any, reading to ministrate cause. Enter Underlying	b. Use to	ривлен ut):									
b	ecutec and -transi	al Examiner	any, issuing to minisulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	quence of):										
8/00,	icate be executed physician and the burial-transit			Due to	(or as a consec	quence on.								
9	tificate ig phys as the	ledical		d										
ROX	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths?		utcome pf pregn birth 2 ☐ Fet		Ectopic pregnanc	y			23d. Date of deliv		'ear	
5	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of nown	death 5	Other (specify)				WOTE	Day	eai	
ī,	that the poly detact		Part II. Other significant conditions	nderlying cause giv	ven in Part I.	23e. Did	id tobacco use contribute to the cause of death?							
Hecords	w requires that been signed to should be deta	ed by							_ 1□	] Yes 2	□ No 3 □ Pro	bably 4 🗐	nknown	
ecc	aw Is b	plet							24a. Wa	opsy	24b. Were aut	opsy findings a ompletion of ca	vailable use of	
	(6 -	Completed							per 1□ Yes	formed?	death?	2□ No		
VITAI	Physician: The I this certificate ha ral director, page :	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:	Inpatient 2	7.FB/O. 44i	Ott	nor:	Death (Check only		- 10	Așsis	sted	
ō	Phy this	n: <b>T</b> 0	27. Manner of Death	ER/Outpatier 28b. Time of Injury	4 Nulsing Home 3 Hesidence of Cother (Specify)					<sup>ity)</sup> Livin				
100	ending Fath. or: After he funer	atio	1 ☑Natural 5 ☐ Pending investigati	M 1 □ Yes 2 □ No										
DIVISION	i or Attend after death I Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	reet, factory, office 28f. Location ( City or To			(Street and Number or Rural Route Number, own, State)							
_	spital or ours afte neral DII		29a. Certifier 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									)		
	To ti Withi To ti com	M	29b. Signature and title of certifier				29c. License number				29d. Date signed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )			
_	1		> saoha				000	23322	-		0.9/.	2010.		
	4		30. Name and address of person who S.S SACHIDEV 1	o completed cau	ise of death (Ite 26 A E	m 23a) (Type,	Print) Fe	le Con D	10 21921					
	Sta	te	31. SEP 1/3 1/2010 (ear)	MD 1	Registrar's Sign	ature		//		•				
	Registr	ar	7		14	PO. P								

Registrar

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State

M. D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark

SEP 1 3 2010

august 27th 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 23. Day Physician/ 2010 6:05 A M August Vicencia S. McDowell Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Bowie Rose's Place Assistant Living 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) New York 1 🗆 M 2 🍱 F Min. Months 71 1938 Dec. Director 122-30-7652 Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 X Yes 2 No Bowie Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 72 hours after death with 20715 United States 13426 Overbrook Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married African 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 3 Widowed 4 X Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Government Teacher of Health and Mental Hygie If item 27 is marked other r other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Rachel Decker Robert Alves and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3600 Kidder Road Clinton, Maryland Deborah Williams/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September Page 1 0 E 0 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 2010 Suitland, Maryland Washington National ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4001 Benning Road NE Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Physician/ Senile Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or iinjury that initiated events resulting in death) Last nding physician and use as the bunial-tran Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year fo Pregnant at time of death 5 Other (specify) the a signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 26. Place of Death (Check only one) 25. Was case referred to medical Be 4 Nursing Home 5 Residence 6 X Other (Specify) Center examiner? Other: Certificate: To 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death work? 1 XNatural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Upton Street NW Washington, DC 31. Date filed (Month, Day, Year, 32. Registrar's Signature State AUG 3 0 2010 Registrar

ynthia M Williams

3 🗌

Signature and title of certifier

29a. Certifier

(Check

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

58032

29c. License number

20016

29d. Date signed (Month, Day, Year)

August 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-06582 State of Maryland / Department of Health and Mental Hygiene **Emily Molin** 1- For State Certificate of Death Registrar Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day September 1, 2010 0138 hrs Medical Examiner Emily B. Molin 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury Peninsula Regional Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** oreign Months Davs Director MD 05/19/1925 Country) 220-12-0623 1 M 2 X F 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No 28a-f show s 23a or 28a-f shove e notified at once. Delaware Darby permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sht injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 19023 <u> 20 Summit Street</u> 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Funeral 12, Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 Never Married 2 Married 1 Yes 2 X No white 1 Yes 2 No specify: Specify. 3 X Widowed 4 Divorced If Yes, Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Rail Roads Clerk 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estelle Taylor Clarence Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Hillary Mitchell- Brother Belvedere Dr. Mechanicsburg, PA 17055 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sep. 8, 10 Berlin, MD Evergreen Cemetery 4 Dopation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Burbage Funeral Home 108 Williams Street Berlin, MD 21811 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Maidigai Death Multiple injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 27,28a-f, per ME g910 12/13/10 TT the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death Year 1 Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed by ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other After this 1 Yes 2 ဥ 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: Yes 2 No 1 Natural 11:45 pm 5 Pending within 24 hours after death. To the Funeral Director: 8/31/10 the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be orTown, State) Carey Road near Rte 113 Berlin, MD Suicide roadway (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year) SEP 0 7 State Registrar

Medical

29b. Signature and title of certifier

Laron Locke MD.

arke

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year) September 1, 2010

and manner stated

Assistant Medical Examiner

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Physician/ Medical Month Kemper Lee Mills III 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HIOMICO SALISBURY MAGICAL . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Min May I, Day Year) 1 M 2 F Hours Washington DC Director 72 578-50-4302 Usual Residence of Decedent 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Directo 1 X Yes 2 No Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 27289 Oriole Road 21853 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 White 1 ☐ Yes 2X☐ No Specify: Il Hygiene. other than "natural", 3 Widowed 4 Diverced Completed Year or Dates. Army 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military Police Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Lillian Evon Ryan Kemper Lee Mills Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6505 Tufts Dr. Elkridge, Maryland 21075 Wayne Mills/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Arlington National Cem. 9/15/2010 4 Donation 5 Other (Specify) Arlington, Va 22. Name and Address of Facility Signature of Funeral Service L Huntt Funeral Home MOUGO 3035 Old Washington Rd. Waldorf, MD 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Empyema disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Show Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-transit Methbolic acidosis Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ER/Outpatient 3 DDA ည 1 Nnpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) raia 068222 8/23/10

BBION State

Baltimore,

68760

Box (

Ö

Records,

**Division of Vital** 

Registrar DHMH 17 Rev 7/2009 100E. Carroll St. SAlisbury, Md. 21801

2. Registrar's Signa ure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raza Afzal

31. Date filed (Month, Day, Year) AUG 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 22 per FH G907 9/15/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruth Magness Plowman August 29. 2010 5:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Cecil 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 2 2 2 – 1 2 – 6 4 1 8 **Funeral** 1 🗆 M 2 🕱 F Months 0370171927 Delaware Director Usual Residence of Decedent ermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland repartment of Health and Mental Hygiene.

mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County Cecil 10c. City, Town or Location 10d. Inside City Limits Maryland Director Warwick 1 Yes 2 XNo 10e. Street and Number 32 Charles Lane 10f. Zip Code 10g. Citizen of What Country? Funeral 21912 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Interior Design Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur ပ္ J. Magness Marguerite Gray 19a. Informant's Name/Relationship (Type, Print) Carolyn Evans/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4 Cherry St., Chesapeake City, MD. 2 21915 Baltimore, 20b. Place of Disposition (Name of Crace, Cemetery, Germatory or other place)
Church Cemetery 20c. Location - City or Town, State  $2 \quad \text{Wilmington,}$ 20a. Method of Disposition September 2010 DE 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Searce Ligansee 22. Name and Address of Facility Galena Funeral Home MOOSIO Galena MD 118 W Cross St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions. Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Yes I X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge dueth concurred at the time, date and plane, and due to the nausu(s) and manner as state 29b. Signature and title certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OUSON nth, Day, Year) 32. Registrar's Signature State AUG 3 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b,c,perFH,G90/,9/16/2010,WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 ODESSA PRICE 2010 6:25 aM 23 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING Social Security Number 7. Age (In vrs. last birthday) If Under 1 If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 M 2 Davs Hours Min. MARCH 10,1920 **Director** 90 578-32-5076 WASHINGTON. Usual Residence of Decedent within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 17₺¥Yes 2 □ No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1220 12th ST. NW #302 20005 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give n "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 thNo Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry if. Page 1 and 2 should be mediated the figure.

artiment of Health and Mental Hygiene.

artiment of Health and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL GOVERNMENT 12yrs SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LEO WHITE FRANCES LONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET S. CONYERS COUSIN 1906 GAITHER ST. HILL CREST HEIGHTS MD 20748 Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 and Department of F Lificolm Cemetery of other olace)
TURNER MEMORIAL া Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland HYATTSVILLE 8<del>/30</del>/2010 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC Sonature of Funeral Service Lio nsee 3005 12th ST. NE WASHINGTON, DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) ACUTE RESPIRATORY DISTRESS Medical Due to (or as a consequence of): Examine SEPSIS Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Unin to (or as a nonseque; ne of) PNEUMONIA signed by the attending physician and defacthed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 \*\*No Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2N☐ No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: မ 1 3 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 15 Natural 5 Pending injury work' 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 8/30/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUGANTHI ALAGARSAMY 1500 FOREST GLEN RD. SILVER SPRING MD. 20910 31. Date filed (Month, AUG 3 1 32. Regist State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ August 2010 1413 Рм Margit Emelie Quist Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 235 Nottingham Road Elkton 8. Date of Birth (Month, Day, Year) April 10, 1941 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 V F Hours 204-32-4629 69 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No E1kton Maryland Cecil 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 21921 United States 235 Nottingham Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Maryland 21215-0036 Completed by 1 Never Married 2 Married 2 X No ☐ Yes 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 X Divorced White Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumation." Animal Care/ Elementary/Seconday (0-12) College (1-4 or 5+) Animal Care/Farming AgricultureBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Helmi Eklund Harold Quist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nottingham Road, Elkton, Diana M. Clark/Friend 235 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 31, 2010 1 ☐ Burial 2 ីX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. ris & Co., Inc. 2010 West Chester. PA
22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed n.24 hours after death. is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transi Cause (Disease or Imiury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print onson 31 Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Jack Ronald Rumble 410AM august Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince Georges Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Year)

Dec. 18, 1942 Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 234-64-9961 1 ★ M 2 □ F West Virginia 67 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Lanham Prince Georges 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5517 Belva Place 20706 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 X Never Married 2 Married 1 ★Yes 2 No If Yes, Give 1960—1964 Year or Dates. Specify: White Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life.\_DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Computer Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret M. Vanata Bruce Ronald Rumble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $P \cdot O \cdot Box 355 Grant Town, WV 26574$ Sherrie L. Haller/Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place). Wash. University Medical Center 20a. Method of Disposition 20c. Location - City or Town, State August 28 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 2010 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Lig /M00969 hi 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between EPSIS Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner CNEUMONIA E Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a sunsequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 No been signed by the should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA Certificate: To : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death

To the Funeral Director; A

completed filled in by the f Accident Investigation Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

Wn

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERFAN

31. Date filed (Month, Day, Year)

AUG 3 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Robert Allah Ro	zeii	1- For State Registrar	tate of Maryland		rtment of tificate of		nd Mental	R	eg. No. 201	0 2865
Physici Medical Exam		1. Decedent's Name (First, Mid-						2. Date of Dea Month August <del>30</del>	Day Year	3. Time of Death 1627 hrs
/ /	11161	Robert Allan R  4a. Facility Name (if not instituti		r)	4	b. City, Town, c	or Location of De		+, ∠U1U 4c. County of Dea	
		12326 Pine Rest Driv	/e			Ocean City	y		Worcester	
Funeral Director		5. Social Security Number 212-06-4347	6. Sex 7. A 1 X M 2 F 26	ge (In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Da		Hrs. 8. Date of Bir Min. 2/1/1	984 984 C	
any		Usual Residence of Decedent  10a. State 10b. County		10c, City, T	Town or Location	on			-	10d. Inside City Limits
<b>*</b>	'n	MD Word	ester	Ве	rlin					1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	untry?
ith the Maryland 23a or 28a-f sho		403 William S	St.		_	2181	1		USA	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Deceder Armed Forces	?			lispanic Origin? an, Mexican, Pu	( Specify Yes or No erto Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
fter de I", or		3 Widowed 4 Di	vorced If Yes, Give Year or Dates:	X No	1	Yes 2 X N	o s <i>pecify</i> :		Specify: W	hite
nours a natura ixami	ed by	15. Decedent's Education (Sp.	ecify only highest grade co				ation (Give kind e. DO NOT use		16b. Kind of Business	s/Industry
036 ithin 72 l ne. r than "r ledical E	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	Coo	_	0. 50 110 1 400	, our out	Restaura	nt
5-00; led with Hygiene I other t	Som	12 17. Father's Name (First, Middle	e, Last)		000		18.Mother's Na	ame (First, Middle, I		
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Scott Latham						A. Rozel		
MD 2. d 2 should th and M n 27 is ma numatic c	٦	19a. Informant's Name/Relation						or Rural Route Nun ${ m rlin,}{ m MD}$	nber, City or Town, Star	te, Zip Code)
e, MC 1 and 2 st Health an item 27 i		Linda A. Roze. 20a. Method of Disposition			ace of Disposit	ion (Name of ce		Date	20c. Location - City of	or Town, State
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		1 Burial 2 X Cremation 4 Donation 5 Other S		late	ematory or oth	erplace) open Cro	em. 9	/3/2010	Frankford	, DE
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	ï	21. Signature of F er Service		Jour	22. Na	ame and Addres	ss of Facility	Burbage F	uneral Hom	
		23a. Part I. Enter the disease, o		1 41 41 F				Berlin,		
Physician /Medical		failure. List only one cause	on each line.					ic of respiratory arti	est, shock, of fleat	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons			1 Intox	ICALION			
,	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	coarronce of):						+
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С							
rted d ansit	Exa	events resulting in death) Last	Due to (or as a cons	sequence of):						2
). Box 68760, the death certificate be executed yoy the attending physician and ched for use as the burial - transit	Physician/Medical	<b>X</b> UNPENDED	X AMENDED 23	a,27,2	28a-f p	er me g	907 9-1	6-10 vt		
760, icate be physicate burnithe burnit	/Me	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, outco	me of pregna	ancy				23d. Date of delive	•
Box 6876 death certificat he attending ph	ician	past 12 months?	4 Pregnant a	t time of deat	<del>   </del>	al death 3 er (Specify)	Ectopic pre	gnancy	Month	Day Year
BO) ne death the att	hys		known 9 Unknown							
ires that the signed by	by F	Part II. Other significant condi	tions contributing to deal	th but not res	sulting in the ur	iderlying cause	given in Part I.		bacco use contribute to	
	eted							24a. Was a	an   24b. Were a	utopsy findings available
CO law has	ompleted							_ autop perfor 1 ✓ Yes	med? death?	completion of cause of
	Bec	25. Was case referred to medica				26.Place	e of Death (Che	4		2 110
of Vital ing Physician: After this certifuneral director,	TO B	examiner?  1 ✓ Yes 2 No			R/Outpatient				Residence 6 🗸 Othe	er: Scene
⊏ ਵੰਤੂੈਵੀ	ü	27. Manner of Death  1 Natural 5 Pen	28a. Date of Inji (Month, Day,)	Year)	28b. Time of Inj		ury at Work? Yes 2 🗶 No	28d. Describe h	now injury occurred	
Division tal or Attendi rs after death.	ficat	2 Accident Inve	stigation 11d 8-31		Ed 4:20 ne, farm, street	pm , factory, office		28f. Location (S	Street and Number or R	ural Route Number, City
Divis pital or At ours after c eral Direc filled in by	Certification		rmined (Specify)	found	: priva	te dwel	Lling			ine Rest Dr. ter Co, Md.
Division  To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	Medical (	Torroom only	hysician: To the best of m miner: On the basis of exa and manner stated.	-					• •	
F¥FS	Me	29b. Signature and title of certific				29c. Licens			29d. Date signed (Mo	
		() (asterte	elis)			O.C.	M.E.		September 1, 20	010
		30 Name and address of person Laron Locke MD. A	who completed cause of a ssistant Medical Ex	. *		Street, Baltii	more, MD 2	1201		
		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature						
Regist	irar	SEP 0	7 2010 Buch	un p	a. ga	Ked				

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

unter Reeder		1- For State	ate of Maryland		tificate of		ila ivicillai i	•	eg. No. 201	0 28652
Physic		1. Decedent's Name (First, Midd	lle,Last)				·	2. Date of Deat	th	3. Time of Death
ledical Exam	iner	nullter James N				U. Cit. T.		Month August 25		0417 hrs
		4a. Facility Name (if not institution Peninsula Regional M	· ·			Salisbury	or Location of Dea	tn	4c. County of Dea Wicomico	aun
Funera		5. Social Security Number		e (In yrs. las	st birthday)	If Under 1 Yo		_	th(MM/DD/YYYY) 9. B	
Director		n/a	1 X M 2 F		Yrs	Months Da	ays Hours M O	in. 12/26	5/2009 Fore	country) DE
' any		Usual Residence of Decedent  10a. State  10b. County		10c. City, T	Town or Locati	on				10d. Inside City Limits
Maryland 28a-f show any d at once.	ğ	MD Worce	ster	Sno	w Hill			·-····		1 Yes 2 X No
e Mary or 28a-	Director	10e. Street and Number				10f. Zip Code		10	0g. Citizen of What Co	untry?
death with the Maryland or items 23a or 28a-f sho must be notified at once	a D	102 Powell St.  11. Marital Status	12. Was Deceden	Ever in U.S	. 13. Wa	218	63 Hispanic Origin? (3	Specify Yes or No-	USA - 14 Race - Ame	erican Indian, Black,
leath v ritem	Funeral		Armed Forces				an, Mexican, Puer		White, etc.	, , , , , , , , , , , , , , , , , , , ,
after o	by F	3 Widowed 4 Div	vorced If Yes, Give Year or Dates:		1	Yes 2 X	No specify:		Specify: W	hite
hours natur Exam	ted	<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>					pation (Give kind of ife. DO NOT use re		16b. Kind of Business	s/Industry
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygene.  tant: If iten 27 is marked other than "natural", or items 23a or 28a-f sh or other traumatic event, the Medical Examiner must be notified at once	ompleted	Elementary/Secondary (0-12)	College (1-4 or	D+)		n/a			n/a	
5-0C led wil Hygien other	၂ ပ္ပ	17. Father's Name (First, Middle	, Last)			•	18.Mother's Nan	ne (First, Middle, N	Maiden Surname)	
21215-0036 ould be filed within 7 Mental Hygiene. I Mental Hygiene. In marked other than ic event, the Medica	8	Grover Charles 19a. Informant's Name/Relations			[40t Mail:			rie Lewi		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.	ဦ	Grover C. Reed				•	t., Snow		nber, City or Town, Star D 21863	te, Zip Code)
e, N 1 and 2 Health item 2	0.00	20a. Method of Disposition				tion (Name of c		Date	20c. Location - City of	or Town, State
MOF Pages ent of int: If		1 X Burial 2 Cremation 4 Donation 5 Other S		ate		Cemeter	v 8/	28/2010	Snow Hil	1, MD
Baltimore, permit. Pages I an Department of Hea Important: If ites		21. Signa re o re ner Service	Licensee	,,,,,,,		ame and Addre			Funeral Ho	
	_	23a. Fart I, Enter the disease, or	complications that caused	the death [					MD 21811	Approximate Interval
Physician /Medical		failure. List nly one cause	on each line.					or respiratory arre	sat, shook, or fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons			, 11011101				
	<u>.</u>	Sequentially list conditions,	b							ļ
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	С							
ted I	Examiner	events resulting in death) Last	Due to (or as a cons	equence of):						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunda - transit	Medical	UNPENDED	AMENDED 7, 1	er ME	o910	12/7/10	<u>т</u> т			
760 ficate to g physicate but the but		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregna	ancy				23d. Date of delive	•
Box 6876  The death certificate the attending phined for use as the	Physician/	past 12 months?	4 Pregnant at	time of deat	h = =	al death 3 er (Specify)	Ectopic pregr	lancy	Month	Day Year
Bo ne deat the at	hys	Control Control Control Control	known 9 Unknown					loo Billi		
ires that the displayed by the	by	Part II. Other significant condit	ions contributing to deat	n but not res	sulting in the u	nderlying cause	e given in Part I.		bacco use contribute to 2 ✓ No 3 Pro	obably 4 Unknown
ords, w require s been sig	eted	1						24a. Was a		utopsy findings available
Recor The law icate has t	Completed	-						autops perform 1 ✓ Yes 2	med? death?	
tal Rectian: The certificate ector, page		25. Was case referred to medica				26.Pla	ce of Death (Check		2 No 1 V	140
Vital Physician:	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	1,	R/Outpatient	3 DOA	Other Nurs	ing Home 5 🔲 I	Residence 6 0th	er:
n of ding Pt After funeral		27. Manner of Death  1 X Natural 5 Pend	28a. Date of Inju (Month, Day,Y	ry 2 ear)	28b. Time of Ir	`	jury at Work? Yes 2 No	28d. Describe h	now injury occurred	
Sior Attend r death ector: by the	cati	2 Accident Inves	stigation 28e Place of In	iun/ - At hom	ne farm stree			28f Location (S	treet and Number or R	tural Route Number, City
Divi	ertification:		d not be (Specify)	jury raction	, 14111, 04 00	, 100101), 011100	building, oto.	or Town, St		caran react rumbon, only
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ပ	29a. Certifier (Check only 1 Certifying Pl	nysician: To the best of m	_						
To the Hos within 24 h To the Fur completely	Medical	2	miner:On the basis of exa and manner stated.	nination and	d/or investigati			at the time, date a		
	2	29b. Signature and little of certifie	1 11	M			nse number		29d. Date signed (M August 26, 2010	
		30. Name and address of person	who completed cause of o	eath (Item ?	(3a)					
		Melissa Brassell, MD	Assistant Medical	,	•	enn Street,	Baltimore, MD	21201		
S Regis	tate	31. Date filed (Mont SEP Year)	7 2010 32. Registra	's Signature	1. do	W.				

OCME

10-06334 Lamar Robinson

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State of Maryland / Department of Health and Mental Hygiene

mar roomson		1- For State Registrar		rtificate of		Wientanin		g. No. 20	0 2865
Physicia edical Exami	an/	Decedent's Name (First, Middle,Last)  Lamar  Robin	ison	•			2. Date of Death Month August 22,		3. Time of Death 0644 hrs
Sulcai Exami	iici	4a. Facility Name (if not institution, give street and no		4	b. City, Town, or Lo	ocation of Death		4c. County of De	
•		Route 50 East of 197			Bowie	Little 1 - Oallis	To Date of Birth	Prince Geo	
Funeral Director		5. Social Security Number  248 37 1387  Usual Residence of Decedent  6. Sex	7. Age (In yrs.	Yrs.	Months Days	If Under 24Hrs Hours Min.	_	TEO.	Birthplace (State or reign South Carolina
any		10a. State 10b. County	10c. City	, Town or Location	on				10d. Inside City Limits
land f show	ō	Maryland Anne Arundel		Crofton					1 Yes 2 No
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 2526 Vineyard Lane			10f. Zip Code 2111			g. Citizen of What C United St	ates
ath wit items 2 ist be n	Funeral	1 V Never Married 2 Married Armed F			Decedent of Hispa s, specify Cuban, N			14. Race - Ar White, et	nerican Indian, Black, c.
after de 11", or ner my	by Fu	1 X Yes 3 Widowed 4 Divorced If Yes, Give Ye	2 No ar	1	Yes 2 XX No	specify:		Specify:	Black
hours : natur:		15. Decedent's Education (Specify only highest gra			's Usual Occupation st of working life. D			16b. Kind of Busine	ss/Industry
)36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (	1-4 or 5+)	Maste	er Sgt			USAF	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Co	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·	18		(First, Middle, M	aiden Surname)	
121 Id be fi Aental 18rked event,	Be	Nelson Robinson  19a. Informant's Name/Relationship (Type, Print)		19h Mailing	Address (Street a		a Roper	per, City or Town, S	tate Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	7	Barbara Robinson (mother)			annonbridge				
re, N : 1 and F Health Fitem er trau		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal f			tion (Name of ceme	etery,	Date 31-2010	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify:		rt Jackson	n National (	Cemeterv		Columbia,	S.C.
Balt permit. Depart Importinjury		21. Signature of Funeral Service License	Lace	22. N	ame and Address of Ty Road, Cl.	of Facility <u>Lee</u> inton MC	Funeral Ho	ome,Inc 6633	3 Old Alexandria
Physician		23a. Part I. Enter the disease, or complications that of	caused the death	n. Do not enter th	e mode of dying, su	uch as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple In	juries						Death
		h	a consequence o	of):					
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as cause. Enter Underlying Cause	a consequence of	of):					
	Examiner	(Disease or injury that initiated C.	a consequence o	of):	60				
ecuted and transi	a E	d							
60, ate be ex hysician re burial	edical	UNPENDED AMENDED	autoama of proc	ananov.				23d. Date of deli	verv
5876 ertificat ding ph	_≥	23b. Was decedent pregnant in the past 12 months?		2 Fet	aldeath 3	Ectopic pregna	ancy	Month	Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unkn	nant at time of de lown	eath 5 Oth	er (Specify)				
Vital Records, P.O. Box 68760, hysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and I director, page 2 should be detached for use as the burial - transit		Part II. Other significant conditions contributing t	o death but not i	resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
S, P uires th n signe Id be d	ed by						1 Yes		Probably 4 Unknown a autopsy findings available
cord law req has bee 2 shou	Completed						autops perforr	y prior	to completion of cause of
Re( i: The ifficate r, page		25. Was case referred to medical			26 Place of	of Death (Check	1 Yes 2	No 1 🗸	Yes 2 No
Vital ysician his cert directo	o Be	examiner?  1 Yes 2 No Hospital: 1	Inpatient 2	ER/Outpatient				Residence 6 🗸 0	ther: Scene
Ing P After funera	$\vdash$	27. Manner of Death 28a. Date	of Injury h. Day Year) , 2010	28b. Time of Ir 0000 hrs				ow injury occurred in collision with	vehicle
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be 28e. Place	ce of Injury - At h Major Roa		t, factory, office buil		or Town, St		Rural Route Number, City
o the Hosp ithin 24 ho o the Fun-	Medical (	29a. Certifier 1 Certifying Physician: To the be one 2 Medical Examiner: On the basis and manner	of examination a	dge, death occurr and/or investigati	ed at the time, date on, in my opinion, d	e and place, and death occurred a	I due to the cause at the time, date a	e(s) and manner as and place, and due t	stated o the cause(s)
- 3 - 3	M	29b. Signifure and title of certifier			29c. License i			29d. Date signed (August 22, 20	
0 1/31 1		30. Name and address of person who sompleted cau			Charat D W	- MD 040			
DD ICA	ote	Laron Locke MD. Assistant Medic	al Examiner egistrar's Signat		Street, Baltimo	ore, MD 212	:01		
Regis	tate trar	אוור סיס מווא	wa B	par					
DHMH 17 Rev 1/2	001	OCME	•	ORIGINAL	-				

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		1	For State Registrar	State of Maryla	nd / Depa	artmer <i>rtificat</i>	t of He	ealth and M Death	lental Hy	giene Reg. No.	010	28654
	Diversity in	-	1. Decedent's Name (First, Middle, Last)						2. Date of D Month	Day	Year	3. Time of Death
	Physici: /Medic	al	MARY		ARA			Landing of Dooth	AUGUS		201	
1	Examin	er	4a. Facility Name (If not institution, give st TRANSITIONS	reet and number)		4b. City,		Location of Death	LLE			-0 Li
			5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)		1 Year	If Under 24 Hrs.	8. Date of Bi (Month, D		9. Bi	rthptace (State or Foreign country)
	Funeral Director			M 2XF 88	Yrs.	Months	Days	Hours Min.	JAN 14	, 192		ryĺand
	pu .	-	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or L	ocation						10d. Inside City Limits
	Maryla f sho	_	Maryland Cecil		E1kton							1 ☐ Yes 2 X No
	r 28a-	rec	10e. Street and Number		Lincon	10f. Zi	Code			10g. Citiz	en of What C	Country?
	th with	Funeral Director	141 Kennedy Bouley			1 -	21921					States
	tems tems	uner	11. Wantai Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dece	dent of His cify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 1	4. Hace - Am Black, Wh	nerican Indian, ite, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ∐Yes 2 ∰ No If Yes, Give Year or Dates:		1 🗆 Yes	2 📉 No	Specify:			Specify:	White
8	within 72 hours after death with the Maryland ena. than "natural", or items 23a or 28a-f show ta Madical Examinan must ke motified at		15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	edent's Usu	al Occupa	ation furing most of work	kina	16b. Kin	d of Busines	s/Industry
218	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	rse retired,			D	Restaui	cant
21	lied w Hygier her th		12 17. Father's Name (First, Middle, Last)		UI OI	perat	or	18. Mother's Nam	ne (First, Middl			lairt
anc	d be fi	o Be	Vito Costa					Rosa (	Unknowr	1)		
aryl	shoul nd Me mark umati	ဥ	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ling Addres	s (Street a	and Number or Ru			Town, State,	, Zip Code)
Ž,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglena. If Health and Mental Hyglena. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, ite M. dical Exertifier must be inclified at		Victor J. Costa/No					in Stree	t, Rock			21661 or Town, State
ore	of He of He if item or oth		20a. Method of Disposition  1		Place of Disp cemetery, cre maculate	ematory or	other plac	e) Sept	ember			
Baltimore, Maryland 21215-0036	t. Pag ntment ntent:		4 □ Donation 5 □ Other (Specify)  21. Signal re of Funeral Service License	Ce	motorn		_	1 . /	010 icks Ho	Ch me fo	nerry l r Fune	Hill, MD erals, P.A.
Bal	permit. Pages 1 Department of H Important: if ite eny injury or ot ance.		21. Signar re of Funeral Service License	" Hick >				Stockto				
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the de	eath. Do not en	nter the mo	de of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	CHRONI	OBST	RUCT	VE	PULMONA	RY DI	SEAS	رع	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):							
	LABITITIES	Į.	Sequentially list conditions,	Due to (or as a cons	equence of):							
4.	uted d ansit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
)\ <u>\</u>	ate be executed thysicien and the burial-transit	Exa	resulting in death) Last	Due to (or as a cons	equence of):							
8760,	ate be ohysici the bu	Ilcal		,								
9 x	Physicien: The law requires that the death certificate be executed tris certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	/Med	IF FEMALE: 2	3c. If yes, outcome of preg	gnancy						23d. Date of	delivery
Box	death attended for u	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩0	1 ☐ Live birth 2 ☐ Fr 4 ☐ Pregnant at time o		□Ectopic □ Other (		<u>'</u>			Month	Day Year
P.O.	by the a	Physician/M	9 🗆 Unknown	9□ Unknown					20. Di	d		to the cause of death?
	res tha igned I be det	δ	Part II. Other significant conditions con	tributing to death but not i	resulting in the	underlying	cause giv	en in Part I.				Probably 4 Unknown
Records,	w requir been si should	Completed							24a. W	ns an	24b. Were	autopsy findings available
Rec	hast ge 2 s	dm							au pe	topsy rformed?	prior	to completion of cause of
Vital	ysicien: The is certificate hi director, page	0	25. Was case referred to medical					26. Place of De	1 ☐ Yes		1	63 20110
fVi	nysicionis cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatient 2	□ER/Outpati	ient 3 🗆 I		4 ( Nursing r	dome 5□R			pecify)
n of	ding Phy h. After thi funeral c		27. Manner of Death t ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury	/	28c. Injur Wor		28d. Describ	e how injur	y occurred	
isio	ttendi death. ttor: A	catl	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home farm	M street fact		]Yes 2 □No	28f. Location	n (Street an	nd Number or	Rural Route Number,
Division	after Direct	Certification;	4 Homicide determined	building, etc. (Spe	ecify)	, 00	,		City or	Town, State	)	
	To the Hospital or Attending P wiltin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, de unation and/or	ath occurre investigati	ed at the time on, in my o	me, date and plac opinion, death occ	e, and due to t urred at the tin	he cause(s) ne, date and	and manner d place, and	r as stated. due to the cause(s)
	o the	Med	29b. Signature and title of sertifier	दान्य सावामाना अवस्था.		- 2	9c. Licens	se number		29d. Da	te signed (M	onth, Day, Year)
	F 3 F 8		100	M.	0		057	1722		AU	GUST :	27 2010
- 1	Q		30. Name and address of person who co	ompleted cause of death (	Item 23a) (Typ	e, Print)	-	-				
			LEONARD RICHARD	SON M.D. 19	338 GR	LENE	TREE	E RUAD #	200 F1	CESVI	LLE M	P 21208
	St Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registral 28655 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 1, **Physician** Starliper 2010 Esther 12:15P.M. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Reeder's Nursing Home Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Day, D4 23) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🕅 F 203-10-2588 1920 90 Waynesboro, PA Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int. If item 27 Is marked other than "natural", or items 23a or 28a-f show int. If item 27 Is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Washington Boonsboro 10g. Citizen of What Country? 10e Street and Number 10f Zin Code US 141 S. Main ST. 21713 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white þ Specify 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ 8 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell W. Marlin Hermie C. Kauffman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1536 Dual Highway Hagerstown, MD Nancy Coulter-Statler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page: Department o Important; If any injury or Brown's Mill Cem. 9/7/2010 Greencastle, PA 17225 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Bowersox Funeral Home Greencastle, PA 17225 521 S. Washington St. Down Approximate Interval Between Onset and Death 3-4 DAW 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, n each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to ( as a consequence of) **Examiner** works Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Yam Stenosin Avite burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical YEMI mmo the as attending IF FEMALE use a 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy Physician: The certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 🗹 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔽 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470 DR. GHAZALA QADIR,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

\*AZLIPER

B. face

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of tificate of				giene Reg. Na	7	2	8656
			Decedent's Name (First, Middle, La	st)						2. Date of De		<u>.                                    </u>	3. T	ime of Death
	Physicia		SOPHIA N.	SUAH						Month AUGUST	23	, 2010		7:44 AM
	Medio Examin		4a. Facility Name (if not institution, give 5912 GRAND BANKS)	· ·			4b. City, Town		of Death		4c	:. County of Deat		
	Funeral Director		5. Social Security Number 6. S 219-27-8946	ех 7. Ag	je (In <i>yr</i> s. las	st birthday) 4 Yrs.	If Under 1 Yes Months Day		er 24 Hrs. Min.	8. Date of Bir (Month, Da MARCH		Co	thplace (S untry) BERI	State or Foreign
	d ow t	]_	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	agtion						10d Inc	side City Limits
	: Marylan 28a-f sh lotified a	Director	MD HOWARD		COLU								12	Yes 2 No
	s 23a or sust be r		10e. Street and Number 5912 GRAND BANKS I	RD			10f. Zip Code 21044				10g. Ci L <b>I</b> B	itizen of What Co ERIA	ountry?	
9000	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1  Never Married 2  Married  3  W Widowed 4  Divorced	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.		ŀ	Vas Decedent of Yes, specify Cu	uban, Mexica	an, Puerto F			14. Race - Ame Black, White Specify: BLA	e, etc.	ian,
1215-(	rithin 72 hou iene. r than "nat the Medica	Completed	15. Decedent's I (Specify only highest go Elementary/Seconday (0-12) 12th		5+)	(Give I	lent's Usual Occ kind of work dor O NOT use retire	ne during mo ed)	st of workir	-	16b. k	Kind of Business  DOMEST		
Maryland 21215-0036	uld be filed within 7 Mental Hygiene. Parked other than natic event, the M	To Be	17. Father's Name (First, Middle, Last) TOGBAH K. NORWEI	νT				18. Mot		(First, Middle, UAH	Maiden	Surname)		
	and 2 shou Health and tem 27 is m	3	19a. Informant's Name/Relationship ( HARRIET DUNCAN CAI		TER							r Town, State, Zip D• 21044		
ore	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3		се	metery, cren	sition (Name of natory or other p			ate / 1 O		ocation - City or		tate LIBERIA
Baltimore,	permit. Page 1 Department of Important: If i any injury or c		4 Donation 5 Other (Spec		FAN	1 22	CEMETE  Name and Add	dress of Faci		ITOL	MOR'	ARNGBA TUARY ASH., 1		20002
			23a. Part 1. Enter the disease, or co shock, or heart failure. List	plications that call e	d the death.							, ,	Appr	oximate
8	Physician/ Medical	ı	Immediate Cause (Final disease or condition resulting in death)	a. END	OME	TRIA	th Cure	(rus)	CANC	ER			Onse	et and Death
	Examiner			Due to (or as	a conseque	ence of):								
	ed	Examiner	Sequentially list conditions, if any, teating to himmediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a conseque	ance of jr								
	ate be executed bhysician and the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):								
90	ate be ohysic the bu	dical		d										
Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death.  Funeral Director. After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transities.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	Ectopic pregnation of the control of					23d. Date of de Month	livery Day	Year
s, P.O.	res that the des signed by the s I be detached I		Part II. Other significant conditions	contributing to death b	out not resu	ulting in the u	nderlying cause	given in Par	t I.	23e. Did to		use contribute to		se of death?
cord	law require nas been si e 2 should I	Completed by								24a. Was auto	psy	prior to	topsy fin	dings available on of cause of
Be	sician: The law certificate has rector, page 2 t		05.00							perfo	2 N	lo 1  Yes	2 <b>X</b> 1	No
ita	sician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			_ [c	Place of De						<u> </u>
of V	Physer this eral di	e: To	27. Manner of Death	28a. Date of inju	iry 2	28b. Time of	28c. In	4 <u>∟_1</u> jury at		me 5 Resident 28d. Describe h		Other (Spec	ify)	
ouc	nding l ath. r: After ie funer	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		y, Year)	injury	w	ork?	- 1			,		
Division of Vital Records,	al or Attendi s after death Il Director: A d in by the f	Certificate:	3 Suicide 6 Could not l 4 Homicide determined		ury - At hon c. (Specify)	ne, farm, stre	et, factory, offic	e	2	28f. Location (\$ City or Tox		d Number or Ru	ral Route	Number,
_	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 L Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	examination	and/or invest	tigation, in my op	inion, death	occurred at	the time, date a	and place	e, and due to the	cause(s) a	and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier		MD		29c. Lice	nse number	779		^	ust 2	1	2010
12	4		30. Name and address of person who	11 .0 . 11		23a) (Type, F	F140	Colun	bio.	MD	210	45		
	Sta	te	31. Date filed (Month, Day, Year)	- 1	ar's Signatu	ire	7 1 1 1	-0 000	100/	11.7	J-10	10		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28657 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wals Month Physician/ 23 2010 0100 CHERYL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin Chesapeake Hospice House Harwood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth Funeral 1 □ M 2 🗷 F Days Hours Min. 9/18/1960 Months Yrs. Washington, DC **Director** 215-80-9330 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 Bay View Drive 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event. the M College (1-4 or 5+) Owner American Tank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Michael Lee Kidwell Sandra Lee Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Bay View Dr., Edgewater, Maryland 21037 <u>James M. Wells. Sr./ Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Kalas Crematory 8/26/10 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland 21. Signature of Furieral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate et and John Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death been signed by the sahould be detached 1 ☐ Yes ∠ ∪ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 ☐ No DICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? Natural 5 Pending nours after death.

neral Director: Af 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title 29c. License number 21438 Name and address of person who completed cause of death (Item 23a) (Type, Print) TANAPOLIS MAZINOS ENAM

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month

AUG 2 5 2010

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32. Registrar's Signature

TRAHWA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Year Gurtha Mae Wooten 2010 08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Southern Maryland Hospital</u> Prince George's Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) 2/30/1929 1 🗆 M 2 🔀 F Days Hours Min Director 408-42-8449 80 Somerville, Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified any injury or other traumatic event, the Medical Examiner must he notified and since it is any injury or other traumatic event, the Medical Examiner must he notified and since it is a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Hillcrest Heights Prince George's 10e. Street and Number 10g. Citizen of What Country? Funeral 20748 <u>3607\_24th Avenue</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Director Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Barney C. Moore Lillian Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12003 Elmore Drive <u>Marvin Parker - Nephew</u> Brandywine, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 09/02/2010 Brentwood, 22. Name and Address of Facility Ft. Lincoln Funeral Home, 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on 3401 Bladensburg Road Brentwood, MD 20722 complications that caus Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, ner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. ending physician and use as the burial-transit that initiated events resulting in death) Last been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown To the Hospital or Attending Physician: The law requin within 24 hours after death.

To the Funeral Director: After this certificate has been a completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examine? Hospital: 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the bear of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Bactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 L 3 L (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

AUG 3 1 2010

of person who completed cause of death (Item 23a) (Type, Print)

Physiclan: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records. Hospital or Attending

Baltimore, Maryland 21215-0036

State

31. Date filed (Month, Day, AUG 3 1 2010

MEHNUR

29b. Signature and title of certifier

mennus

(Check only one)

PRINCE GEORGES HPEDIH 010 32. Registrar's Signature

and manner stated

Usedm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28189

29d. Date signed, (Month, Day, Year)

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HOST! TAL

eith Deant	hre	2 Washinston				
10-06330		Please Type or Print in Black Indeli				
UNK UNK		State of Maryland / Departme	ent of Health and Mental H hate of Death		2010	2866
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Medical Exami		KEITH DEONTE Was	SHINGTON	Month August 22,		0546 hrs
		Facility Name (if not institution, give street and number)     Prince George's Hospital Center	4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		. 8. Date of Birth		hplace (State or
Director		579739693 1XM 2DF 17	Yrs. Months Days Hours Min.	06/10	11993 Foreig	in Wash.
		Usual Residence of Decedent				40d India Ob Limb
ow any		10a. State 10b. County 10c. City, Town of TEM				10d. Inside City Limit
ryland 'a-f sh	ctor	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a nijury or other traumatic event, the Medical Examiner must be notified at once.	Director	5817 Fisher Boad #OII	20748		OSA	
with with ms 23s	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,
r death wit or items 2	Funeral	1 Yes 2 No	_	rican, etc.)	Bi	nev
rs afte ural", miner	ģ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. If Yes, Give Year or Dates:	1 Yes 2 No specify: Decedent's Usual Occupation (Give kind of v	vork done	Specify: U L  16b. Kind of Business/I	ndustry
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	luring most of working life. DO NOT use reti	red)		,
036 vithin 'i ene. rr than	ldm	9th	Student		1/a	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumartic event, the Medical Examiner.	ပ္ပ	17. Father's Name (First, Middle, Last)	18.Mother's Name			0.0
212. ald be Mental market	To Be	HEITH JOHNSON  19a. Informant's Name/Relationship (Type, Print)  19b	. Mailing Address (Street and Number or F		SHINGT per, City or Town, State	Zip Code)
MD 3nd 2 shot alth and 1 stress m 27 is 1		Tracey Washington / mother 5	5817 Fisher Rd		TEMPLE H	ris, MD.
re, N i and i and Healt fitem			Disposition (Name of cemetery, bry or other place)	Date	20c. Location - City or	Town, State
MOI Pages nent of ant: I		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		3/10	Beltsvill	e, MD.
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	111	4201	1 St. ME.
		23a. PanJ. Enter the disease, or complications that caused the death. Do not	enter the mode of dving, such as cardiac o	nerol Ho	t shock or heart	Approximate Interva
Physician /Medical		failure. List only one cause on each line.	conton are mode of dying, each are cardinal	, roop, and	, , , , , , , , , , , , , , , , , , , ,	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound of Head Due to (or as a consequence of):				
	L	Sequentially list conditions, b.	50 Ti			
	nine	if any, leading to immediate  cause. Enter Underlying Cause  C.  Due to (or as a consequence of):				
क्षेत्र हैं।	Exan	(Disease or injury that imitated events resulting in death) Last  Due to (or as a consequence of):				
ox 68760, estin certificate be executed attending physician and for use as the burial - transit	calE	d AMENDED				
50, te be e	sician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 68760, e death certificate be the attending physic ed for use as the bur	an/I	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna	ncy	manufacture of the same	ay Year
Box 6  The death cert  The attendit	sici	4 Pregnant at time of death 5	Other (Specify)		l.	
that the detached	Phy	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	he cause of death?
ires that signed	d by			1 Yes	2 No 3 Prob	ably 4 Unknown
ords, w requir	Completed			24a. Was ar autops		opsy findings available ompletion of cause of
Vital Recor	omp			perform 1 <b>V</b> Yes 2		s 2 No
al R	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check of	only one)		
of Viting Physic	To	1 Yes 2 No Inpatient 2 Y ER/Ou			esidence 6 Other	
n o	ion:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month: Day, Year)  FOUND: Pour Say, Year)  FOUND: Pour Say, Year)	ime of Injury 28c. Injury at Work?  ND: 1 Yes 2 ✓ No	Subject shot	w injury occurred	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	Certification:	2 Accident Investigation Aug 22, 2010 0450	hrs m, street, factory, office building, etc.	28f. Location (St	eet and Number or Ru	al Route Number, City
Div ital or ral Di	ertil	Suicide 6 Could not be determined (Specify) Major Road / Hig	jhway	or Town, Sta Kenilworth Ave	ite) nue and Eastern Ave	enue, Fairmount He
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal				
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
	2	29b. Signature and title of certifier	29c, License number O.C.M.E.		29d. Date signed (Mor August 22, 2010	iii, Day, rear)
1		30. Name and address of person who completed cause of death (Item 23a)	J.J.M.E.			
4 1		Ana Rubio MD. Assistant Medical Examiner 111 P	enn Street, Baltimore, MD 21201			
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist	rar	SEP 1 3 2010 Jenus B. San				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me g921 11-4-11 yr. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Menth М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. C of Death KIRK CIWI MON If Under 1 Year If Under 24 Hrs. 9. Birthplace (State C.). Country CONNECT CUT Social Security Number 6. Sex Age (li last birthday 8. Date of Birth **Funeral** Days 1 M 2 DF Months Hours Min. (Month, Director Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. State 10b. 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral bono Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Forestulle 140 RNQ inunar boro 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Riverdate 5 ☐ Other (Specify) 4 Donation Funeral Service Videos 21. Signature Home N1020146 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Dh Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ا 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician. المالية على المالية على المالية على المالية على المالية المالية على المالية المالية المالية المالية على المالية المال APPROVED BY MEDICAL EXAM Physician/Medical Sion Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Ses 2 No Month Year 5 Other (specify) Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital Other: Certificate: To SB/Outpatient 3 □ DOA 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manna of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred injury tural 5 Pending 2 🗆 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the To the within 7 29b. Signature 29d. Date signed (Month, Dav. Year) s of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signatur State AUG 3 0 2010 Registrar

Registrar

State

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Harry Alan Zentz August 04:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 48 East Drive Ceci1 Rising Sun 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign County rederick 1958 Maryland If Under 1 Year If Under 24 Hrs. **Funeral** 1**XX**M 2 □ F Months Days Hours Director 56 213-64-6166 Usual Residence of Decedent show 10a. State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Ceci1 Rising Sun 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 48 East Drive 21911 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White Completed 3 Divorced Specify: Maryland 21215-00 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) uld be filed within 7 I Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) <u>Cooperative Fire Specialist</u> Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Philip L. Zentz Betty Blickenstaff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Wilma V. Zentz / Spouse 48 East Drive, Rising Sun, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s Department of F Important: If ite 20c. Location - City or Town, State September 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Blue Ridge Cemetery 2, 2010 Thurmont, Maryland 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) anon Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year ped the ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ဂ 1 Yes this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b, Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director, Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State)

State Registrar

соmpleted

the

within 7

Medical

29a. Certifier

29b. Signature

(Check

only one)

tile of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

onson

MD

32. Registrar's Signature

1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 30

Medical Examiner: On the basis or examination and/or investigation, in the opening, beautiful date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 10 2010 2:40 pm Robert Dominy Arnold Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 D F Hours Country) NY Director 90 122-12-9934 7/22/1920 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme ??... any injury or other traumatic event. The Merican Once. or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville MD Montgomery 1 Yes 2 XXVo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 18110 Cashell Road 20853 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married 1 k X/es 2 □ No If Yes, Give Year or Dates. WWII 1 ☐ Yes 2XXNo Specify. Specify: White Completed 3 √ Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Clothing Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mable Dominy Clifford C. Arnold 19a. Informant's Name/Relationship (Type, Print) 616 Pipingrock Dr. Silver Spring, MD 20905 Carol Whitney, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Beltsville, MD Chesapeake Crematory 9/14/2010 . Signature of Uneral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. M Silver Spring, MD 20910 933 Gist Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death the 9 Unknown g 🗌 Unknown n signed by t<sub>r</sub> Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ chronic obstructive airway disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 🛱 No Other: 1 🔲 Yes မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospice within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ည State

> Registrar DHMH 17 Rev 7/2009

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu C. Joseph MD; 1160 Varnum Street NE #021 Washington DC 20017

D0060634

29d. Date signed (Month, Day, Year)

9/10/2010

heodore Claude Adams Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 1, 2010 **Medical Examiner** 2001 hrs Theodore Claude Adams, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 8608 Lawrence Hill Road Perry Hill-Perry Hall **Baltimore County** 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9, Birthplace (State or 333-36-3751 Director Months Days 67 unk 1 M 10/17/1942 2 F Country) IL Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoo or other traumatic event, the Medical Examiner must be notified at once. Baltimore 1 X Yes 2 No Perry Hall Director 10e. Street and Number 10g. Citizen of What Country 8608 Lawrence Hill Rd USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces White, etc. 1 Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify ģ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Unk. Chemist 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ola Stopen <u>Theodore Claude Adams</u> 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ola Adams/Mother Anderson Lane Green Bay, Wisc, 54304 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Sept. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department o Betlsville, MD Chesapeake Crem. 2010 Donation Other Specify: 21. Signature of Funeral Service License 22. Name and Address of FaciliCAFA/Stephen D. Lohrmann P.A. 8717 Green Pastures Dr. Balto, MD 21286 Mas 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Atherosclerotic cardivoascular disease complicating Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): left nemothorax Probable rupture of pulmonary bleb Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial - tran sician/Medical per me,5 per fh g907 9-17-10 line a-b, PII,27,per ME g908 X UNPENDED X AMENDED vt 10/4/10 TT Records, P.O. Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Leukemia 1 Yes 2 No 3 Probably 4 V Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this ٩ 1 🗸 Yes No Director: After to I in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification; 1 X Natural Pending hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be the Funeral Di or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

DHMH 17 Rev 1/2001

gistrar's Signatur

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

outhall, MA

30. Name and addr a fp. fson who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner

Tuming

31. Date filed (MoSEP

September 2, 2010

# SEPTEMBER 10, 2010 8:23 p.m.

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			for State Registrar	State of M	aryland / [		artment of I tificate of I	Health and Death	Mental Hy	/giene Reg. N	201	0 28666
	Physicia		1. Decedent's Name (First, Middle Lois	_	Armico				2. Date of D Month	eath	ay 10,201	3. Time of Death
N-Way	Medi Examir		4a. Facility Name (if not institution	. give street and number)	Armige	I	4b. City, Town, o	r Location of Deat		$\neg$	c. County of De	
1	, 		Stella Maris				Timor	nium			Balti	
- Specifical	Funeral Director		5. Social Security Number 176–14–8486	6. Sex 7. Āg 1 □ M 2 🏋 F	e (In yrs. last birti 89	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of B (Month, D May 2		921 Pe	Birthplace (State or Foreign Country) ennsylvania
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	Usual Residence of Decedent  10a. State  10b. County		10c. City, Towr	n or Loc	cation					10d, Inside City Limits
	r 28a- notifie	Director	Maryland Balti	more	Tim	<u>oni</u>	um 10f. Zip Code	-				1 ☐ Yes 2 🌠 No
	with the 23a c	Funeral	42 Norwick Ci	rcle			210	103		10g. C	itizen of What	Country?
	items		11. Marital Status	12. Was Decedent I Armed Forces?	ever in U.S.	13. W		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	-		nerican Indian,
36	after or II", or xamin	d by	1 ☐ Never Married 2 ☐ Marri 3 👿 Widowed 4 ☐ Divorced	ied 1  Yes 2 X	No	1	Yes 2 No		o Hican, etc.)		Black, Wh Specify:	nite, etc.
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ary	hould and Me s mar umati		Raymar C.  19a. Informant's Name/Relationsh	Douglass ip (Type, Print)		. Mailine	a Address (Street :	Izetta  and Number or Ru			bersbe:	
Σ	nd 2 sl ealth a nn 27 i		Frank A. Armige	er, Jr./Son	- 1			Circle, T				21093
ore	ye 1 av it of H If iter or oth		20a. Method of Disposition 1   Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Place of	Dispos	sition (Name of atory or other plac		Date		ocation - City	or Town, State
Baltimore, Maryland 21215-0036	iit. Pag artmen ortant: injury	1	4 Donation 5 Other (S	pecify)	Cedar I		L Cemeter	4				Maryland
Ba	permit Depar Impor any in	į ()	Bryan W. Cla	ir		Le 10	name and Address mmon Fun W. Pado	ss of Facility neral Hom onia Road	e of Du	lane ium.	y Valle Marvla	ey Inc. and 21093
P	nysician/		23a. Part 1. Enter the disease, or shook, or heart failure. List o Immediate Caus (Final	ly one cause on each line	the death. Do no	ot enter	the mode of dyin	g, such as cardiac	or respiratory a	rrest,	-	Approximate Interval Between Onset and Death
(	Medical Examiner		diseas tor condit in resultin hin death	a. SEPSIS  Due to (or as a	a consequence o	f):						
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Box 68760	attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □	Ectopic pregnance	'V			23d. Date of d	lelivery
. Bo	this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 🗶 No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)				Month	Day Year
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Į Z	this o	٤	1 Yes 2 X No	1 Inpatie	nt 2 ER/Out			4 □ Nursing H				ecify) HOSPICE
0	l lefe 13	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investig	(Month, Day		jury	28c. Injury work' M 1 🔲		28d. Describe I	now injury	y occurred	
Division of Vital	ifter dez Virector in by th	Certificate:	3 Sulcide 6 Could n 4 Homicide determine	ot be	ry - At home, farr (Spec <i>ify</i> )	m, stree			28f. Location (S			ural Route Number,
<u>ה</u>	neral C		29a. Certifier 1 Certifying	Physician: To the best of r	ny knowledge, d	eath oc	cured at the time.	date and place, a	ad due to the ca	ueo(e) an	d mannor as s	tated
4	To the function of Atlanta  Within 24 hours after death.  To the Funeral Director: A completed filled in by the function.	Medical	only one) 3 X Certifying	aminer: On the basis of ex Nurse Practioner: To the b	amination and/or	investic	gation, in my opinio eath occurred at the	n, death occurred a time, date and pla	t the time date of	nd place	and due to the	cauca(a) and manner stated
, <u>,</u>	2 ∰ <b>2</b> ⊗		29b. Signature and title of certifier	as CANP			29c. License	number		29d. Dat	e signed (Mon	th, Day, Year)
,	3V	ŀ	30. Name and ddress of person w	ho completed cause of de	ath (Item 23a) (Ty	ype, Pri	nt) 7 7	1110		-4	10/0	-, -
	/		JACKIE JONES .  31. Date filed (Month, Day, Year)		ULANEY V	VALI	EY RD.	TIMONIUM	MD 21	093		
	Stat Registra	_	SEP 1 4	2010 32. Registral		1	harles					
	4 17 Rev 7/20			1	10.	1		_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Physician/ 01:45 AM 2010 Septembe Francisco Armada Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Union Memorial Hospital 8. Date of Birth (Month, Day, Year March 13, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Social Security Number Funeral Hours 1 **X** M 2 □ F Months Cuba 89 Director 214-62-8650 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director Examiner must be notified 1 X Yes 2 ☐ No Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 9 10e. Street and Number 23a ( Funeral 3119 Belair Road Cuba 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. 12. Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. "natural", or þ 1 X Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Masonry Bricklayer 12 Be permit, Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Soledad Armada David Armada 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sara Armada/Sister 2909Louise Avenue, Baltimore, Maryland 21214 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9-15-10 Towson, Maryland 4 Donation 5 X Other (Specific ntombmer ProspectHillCem. 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician Myocardia Medical resulting in death) Due to (or a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown Division of Vital Records, P.O. cate has been signed by 1; page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 7
 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Impatient 2 ER/Outpatient 3 DOA မ Date of injury (Month, Day, Year, Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature, and title of certifie AT 2438946 11110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 21218 HOSPITAL AN UNION MEMORIAL

Registrar

DHMH 17 Rev 7/2009

State

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 Physician/ William M. Banks, Sr 2010 12:00ª M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1014 1400 E. Madison Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** XX M 2 D F 92 Hours Min. (Month, Day, Year) Director 215-03-0324 MD Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 72 hours after death with the Maryland the Medical Examiner must be notified at Director XXYes 2 No na MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Madison Street Apt 1400 E. 1014 21205 US items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **XX**No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ō 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic avent than "natural". 3 🕅 Widowed 4 □ Divorced Black Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tailor Factory 9th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Banks Bertha Mae Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2921 Edgewood Circle North Balto, MDEvelyn R. Swann-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pk:9-13-2010 Randallstown, Memorial . Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H hMellan 101  $\mathbf{E}$ North 21202 Avenue Balto MD 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death corona Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 \ No signed by the a g 🗌 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? this certificate 2 🗌 No Yes Division of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 4 Nursing Home within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident (Month, Day, Year) work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who con

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31. Date filed (Month, Day, Year)

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ath (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5 entember Day 12 Lance Bayton 09:00 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randallstown 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 11-08-1958 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 💢 M 2 🗆 F Days Hours Min. 216-74-2824 51 Country) Director Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland n and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDn/a Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 3301 Winterbourne Road USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married δ Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: African-American Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metalist Steel Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev William A. Bayton Sr. Joan B. Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5819 Glenkirk Court, Baltimore, MD 21239 Gaystella Armstead/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State King Memorial Park 9-17-2010 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ a Non-ischemic Cardiomorath disease or condition resulting in death) year. Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death cerlificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) ing physician as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Dav Year peu the 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death? this certificate 2 No Yes 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manper of Death Certificate: After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 🗌 within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Septent-12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934 Aviation Blud. 21061 Vn/ebaum 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year 2010 7:52 amue Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medical Center Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Davs Hours Min. APR 5 Director 88 Yrs 1922 SOUTH CAROLINA 248-28-5181 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland al Hygiene. 10a State ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10b. Counts 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2XXNo MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 CLOVERWOOD CT. UNIT 201 21221 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give by 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 □ Divorced Year or Dates. 42/47 Specify: BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) rthan " the M Elementary/Seconday (0-12) College (1-4 or 5+) th and Mental Hygien 27 is marked other the traumatic event, the 8th grade BRICK MASON CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill trent of Health and Mental rant: If item 27 is marked vilury or other traumatic ew 2 DOC BRIDGES GRACE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eyvonne Bridges-LeaK/Daughter 4 Cloverwood Ct., Unit 201, Baltimore, Md., 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX urial 2 Cremation 3 Removal from State cemetery, crematory or other place) permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) SANHILL MONTROSE 09-18-2010 CHESTERFIELD CO., S.C. 21. Signature of Funeral Service WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVENUE, BALTO, MD. 21217 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Retween Immediate Cause (Final Onset and Death Physician/ Shoc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day 2 No signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Disease performed? Yes 2 ☑ No Periphera Vascular 1 Yes 2 No 25. Was case eferred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 24 hours after death.
Funeral Director: After this leted filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work?
1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phelan Timothy Baltimore MD 21201 MD 10 N. Greene St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP Registrar

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status  1 ☐ Never Marri 3 ☐ Widowed		ried	Armed Fo 1 Yes If Yes, Giv Year or Di	orces?		).   I	If Ye	es, spec	ify Cuba	n, Mexic Specii	an, Puerto	Rican, etc.)	0-	14. Rad Blad Specify	ck, Whi			
hours nature dical E	lete		15. Decede	nt's Edu	cation			16a. Dec					ost of work	ina	16b.	Kind of B	usiness	s Indust	ry	-
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uld be d Ment marke natic	욘	Thomas		hi- Œ	e Print)			T			/2:			A. Tas			24-4- 7		1	
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Physician/ / Medical		Immediate Cause ( disease or condition resulting in death)	n	e a	. Due to	Of as	V G e		VE	21-	eA	RT	- [-]	ALCU	re			X	PA	RS
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red	Examiner	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or	iinjury		Due to	(or as	a consequ	ence of):												
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cate be physicials the bur	edica			•	l															
th certifi	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23	3c. If yes, out 1 ☐ Live 4 ☐ Preg 9 ☐ Unk	Birth nant a	2 Feta	I death 3		Ectopic p Other (sp		у				23d. Da	ite of de	elivery Day	у	Year
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requires been sig	eted	STAPL		-					μι	10	>			1 L 24a. Wa						Unknown
The law ate has be page 2 s	Completed	ACUT			ABET				17	us				aut pe	topsy rformed s 2		prior to death?	compl	etion of	cause of
ysician: The la is certificate ha director, page?	B	25. Was case referred examiner?  1 Yes 2	ed to medical	Ĥ	ospital:	11		ER/Outpat	A! A	0 D DC	Othe	ar.	eath (Chec			2 201	- 1	105	PIC	e
ding Phys th. After this funeral di	cate: To	27, Manner Death  1 Natural 2 Accident			28a. Date	of inju		28b. Time injury	of		Bc. Injury work	at at		ome 5 Re 28d. Describe				сну)		
or Attendi after death. Director: A in by the fu	Certificate:	3 Suicide 4 Homicide	6 Could determ	not be	28e. Place buildi		ury - At ho c. (Specify		street	, factory				28f. Location City or To	(Street a own, Sta		er or Ru	ural Ro	ute Numi	ber,
To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi	Medical	(Check 2	Certifying Medical E	xamine	er: On the bas	sis of e	xamination	and/or inv	estiga/	ation, in r	ny opinic	n, death	occurred a		e and pla	ce, and du	e to the	cause(		anner stated.
To the within To the comple		only one) 3		, iturse	Fractioner:	//	m)	Knowledg	o, uea	29c	License	number			29d. [	Date signe	d (Mont	th. Dav.	Year)	.6
61		30. Name and addre	ess of person	who col	mpleted caus	se of d	eath (item	23a) (Type	e Prin	1†)	De	to:	36	<i>)</i>	Sef	TOM	BOR	0	20	10
9 V Stat		31. Date filed (Month	h, Ďay, Year)	ANI	400 MS	2	670 ar's Signat	ure N		<b>b</b>		S	Ples	) .#410	5 B	AUTIN	rope	e M	D 2	11204
Registra				4 20		Cen	ma		A	ark	ノ									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** September 8, 2010 8:00 A Bell 01iver Leroy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Maryland Masonic Home Cockeysville 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 91 June 5,1919 Maryland Director 219-01-8532 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Cockeysville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filled within 72 hours after death with nent of Health and Mental Hygiene. 21030 USA 300 International Circle Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: Specify: Aq White 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Soap Manufacturing 12 n/a Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Menta item 27 is marked Thomas Bell Sadie ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara M. Stratmeyer/Daughter 14634 Hyson School Road, Stewartstown, PA 17363 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important; If ite
any Injury or ot 9/13/10 1 N Burial 2 □ Cremation 3 □ Removal from State Timonium, Maryland Dulaney Valley Mem. Gardens 4 Donajion 5 ☐ Other (Specify) Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley
10 W. Padonia Road, Timonium, MD 21093 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1 / nter he disease, or complications that collected shock, or heart failure. List only one cause on each line Immediate Cause (Final disease of the Ition PULMONARY EMBOLISM **Physician** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed gue burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy for Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown ANEMIA Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No page 2 s certificate 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural After Hospital or Attending (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No М 124 hours after death.

The Funeral Director: A pletely filled in by the f death. 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

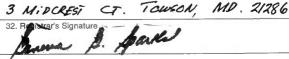
State Registrar

31. Date filed (Month, Day, Year)

C.VERGARA-SOARES

paraloares

29b. Signature and title of certifier



M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the

0

29c. License number

D16619

29d. Date signed (Month, Day, Year)

September 8, 200

10-0658	3
Tommy	Bailev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 0816 hrs Medical Examiner BAILEY TOMMY Т. September 1, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Harbor Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign ARYLAND Min Months Days Hours Director 1**XX**M 09/21/1986 2 214-15-6990 23 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No or 28a-f show traumatic event, the Medical Examiner must be notified at once. BALTIMORE with the Maryland MARYLAND N/A Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code U.S.A. 808 WHITELOCK STREET 21217 or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 2 X No Yes Specify: BLACK Yes 2 No specify: 3 Widowed Divorce f Yes. Give Year permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; injury or other traumatic event, the Medical Examiner. 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) re, MD 21215-0036
I and 2 should be filed within 72 Health and Mental Hygiene. N/A N/A 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DARLENE BAILEY CLARENCE LYDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Mountain Green Cir. Baltimore, Maryland 21244 Denise Bailey-Jones/Aunt 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State 09-11-10 LANSDOWNE, MARYLAND CEMETERY Other Specify Donation 5 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 21. Signature of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Cardiac Arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Myocardial Hypertrophy Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a,b,27 per me g907 9-16-10 vt X UNPENDED After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Dav Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy After this certificate has death? performed' 1 🗸 Yes ✓ Yes 2 ... use Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other DOA 1 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural aeral Director; / 1 Yes 2 No Pending Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sig O.C.M.E. September 1, 2010 d address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME 2006

State

31. Date filed (Month, Day Year SEP 1 4 20

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 9, 2010 Physician/ 4:30 A M Barbieri Angela Rose Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Sunrise of Columbia If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex **Funeral** 7. Age (In yrs. last birthday) 1 ☐ M 2 🏻 F Months December 23, 1929 Days Hours Min. 80 Italy Director 1080-24-1468 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director or 28a-f st notified 1 ☐ Yes 2 ☒ No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 ms 23a or must be r Funeral 6500 Freetown Road 21044 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant. If item 27 is marked other than "natuiury or other traumatic event, the Medical ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hairdresser <u>Hair Design</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Leonardo Lubrano Caterina Scarpatto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Louis M. Barbieri/ Husband Freetown Road Columbia, Maryland 21044 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State September 1 Durial 2 Cremation 3 Removal from State 10, 2010 4 ☐ Donation 5 ☐ Other (Specify) Rethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home Rockyille, Inc.
300 West Montgomery Avenue Rockville, Maryland 20850 Fureral Service Lice MO 1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy ned by the atter in the past 12 months? Day Year 5 Other (specify) Month 9 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Essential Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page performed 1 Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Assisted
4 \(\text{Nursing Home}\) 1 \(\text{Residence}\) 6 \(\text{\mathbb{M}}\) Other (Specify) Living 2 🗵 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier M.D. D56531 September 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, M.D. 8600 Snowden River Parkway #301 Columbia, Maryland 21045 32. Registraris Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Guy Carrenard 10, 2010 08:14 ä Sept /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson Year | If Under 8. Date of Birth (Month, Day, Year) 11-6-1939 Birthplace (State or Foreign Country) (In yrs. last birthday) 5. Social Security Number Hours **Funeral** Months Days 1XM 2□F Haiti 214-82-8290 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ res 2 No Director Parkton MD 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21120 335 Stablers Church Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 72 hours after 1 ☐ Yes ZXXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No למגר הבחנות באל השא altimore, Maryland 21215-0036 Specify: Specify: Black ò 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) General Practioner Self Employed 12th grade yrs filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be if Health and Mental I Clarita Moe Daniel Carrenard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 335 Stablers Church Road Parkton, MD 21120 Rachel Carrenard-Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1Department of He
Important: If Iten
any injury or oth 1 ☐ Burial **②☐**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (*Specify*) Greenmount 9-14-2010 Balto, MD 21. Signature of Fu Al Service Licensee March East F/H 22. Name and Address of Facility But Must 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hemorrhagic infarction of cerebral cortex and days disease or condition resulting in death) /Medical Due to (or as a consequence of): basal ganglia **Examiner** mypertension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as t attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has page 2 performed' death? 1 XYes 2 No 1X Yes 2 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No 1. Inpatient ို Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760 or Attending Physician: within 24 hours after death.

To the Funeral Director: / To the Hospital

29a. Certifier (Check only

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D47221

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Philip R. McDowell, M.D. 6701 N. Charles St., Towson, MD 21204

State Registrar

Medical

31. Date filed (Month, Day, Year)



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Payed and Medical Description of Payed payed and payed as a feetility harmonic for feetility participation, give a stems and number of a country of peetility participation of the payed payed payed of the payed	_		Registrar			Cer	tificate of L	eath			LU	286/6
Shart Hospital of Sale Sale Sale Sale Sale Sale Sale Sale	•		Barbara B. Clark		_		<u> </u>		Month	Day	2010	4:21 PM
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The part of the pa	Depart Import any inj once,		21. Signature of Funeral Service Licenser	M.W	Mer							Balto. Co.
19ina Koopnaunedy (MBBS RES-000 September 7 20ic 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIEA ROOPNAM INESINGH MBBS SINAL HUSPITALCE BALTIMORE	Medical kaminer	I Examiner	show, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially fet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as	a consequence	ce of):			or respiratory arrest	,		Interval Between
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19 19 19 19 19 19 19 19 19 19 19 19 19 1	rs arrer der al Director ed in by th		3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj building, et	ury - At home c. (Specify)	, farm, stre	eet, factory, office				per or Ru	ral Route Number,
19 1 A Gira Roophaunery L MBBS RES-000 September 7 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIEA ROOPHAP INESINGH MBBS SINAL HUSPITALCE BALTIMORE	the Funera	Medica	(Check 2 Medical Examinonly one) 3 Certifying Nurse	er: On the basis of e	examination an	d/or invest	igation, in my opinic leath occurred at the	n, death occurred a e time, date and place	t the time, date and ce, and due to the c	place, and du ause(s) and m	ue to the on nanner as	cause(s) and manner stat stated.
NIER ROOPNAPINESINGH MBBS SINAH HUSPITALOF BALTIMORE	<b>5</b> 00		19ina Roopn				S RES-					
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#23a&b Per Phy C907 9/14/10 Jh

State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#23e, perPHYS, #14perFH, G908, 10/6/2010, WS

Certificate of Death

Reg. No. 1 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Day 1417 ICHARD SEPTEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NIVERSITY OF MARKEND MEDICAL CENTER If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Hours Min. **Director** 219-58-3619 59 50 Usual Residence of Decedent or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21074 U.S.A. 863 Gaming Square 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc.
White
ecify: Black 1 Never Married 2 Married Completed by 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: • 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Duality Control Inspector General Electric</u> 2th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ <u> Antionette Bonomo</u> Charles Culver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Culver-Wife Gaming Square, Hamstead, Md 21074 863 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Park 9/8/2010 Woodlawn, Memorial Signature of Funeral Service License 22. Name and Address of Facility
March F/H West <u>4300 Wabash</u> Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Cardiomyopathy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Dile to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE ROOME FAILURE 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ALUTE HERATIC FAILURE 24a. Was an autopsy performed Yes 2 After this certificate funeral director, pag 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completed filled in by the f ☐ Accident ☐ Suicide Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green St Baltimore MD 2120, \_ S MO Dole 31. Date filed (Month, Day, Year) **SEP 1 4 2010** Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Michael E. Collins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8105 Main Creek Drive Pasadena Anne Arundel 8. Date of Birth (Month, Day, Year) April 28,1949 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months Hours 61 Director 220-52-3504 Maryland Usual Residence of Decedent 23a or 28a-f show st be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland o Direct 1 ☐ Yes 2 🗓 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Examiner must 3105 Main Creek Drive 21122 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces ō Black, White, etc. 1 Never Married 2 X Married 9 1 ☐ Yes 2 ☒No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates er than "natur the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Hygiene. Elementary/Seconday (0-12) Sales Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file if Health and Mental F item 27 is marked of marked Edward F. Collins Ethel Sirbaugh Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette M. Collins - wife 8105 Main Creek Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery | Sept. 13 Elkridge, Maryland 21. Signature of Funeral Service Light 22. Name and Address of Facility Stallings Funeral Home, PA 3111 Mountain Road, Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Acul Myocas Proysician/ Medical resulting in death) Due to (or as a consequence of) Examiner neumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last burial-transit and Due to ( s a c xis, quence of) the attending physician Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE: use Use Birth 2 Fetal death 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ or in the past 12 months? Month Day Year detached 1 2 No 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? this certificate 1 Yes Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate; To 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death.
Funeral Director: After thi eted filled in by the funeral. 27. Manner of Death 28a. Date of injury (Mpnth, Day, Year) 28d. Describe how injury occurred the patting feeling account with white patting would on the trailer. 28b. Time of 28c. Injury at 5 Pending □ Natural UNK 08/17/2010 2 Accident 1 Yes Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) & D 70 V 2 N 7 N 0 7 Pd.

AS AS NA, MD 28e. Pl ce of njury - At home, farm, street, factory, office building, etc. (Specify) PENTNOR MAYINA Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 504 10 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPIDHAR, ATLUR, 7310 RUCLUE HYPWC Glen Burnie MD21061 Suite 800

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Highway

32. Registrar's Signature

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ose Daniel Cut		Rivera Stati 1- For State Registrar	e of Maryland /	Department of Certificate of			Mental Hy	_	eg. No. 2 (	010	28	67
Physici Medical Exam	an/	Decedent's Name (First, Middle,L						2. Date of Dear Month August 22	th Day Yea		. Time of Deatl	h
Medical Exami		Jose Daniel Cub  4a. Facility Name (if not institution, or			4b. City, To	wn, or Loc	cation of Death	August 22	4c. County o	of Death		
		Washington Adventist H			Takom	a Park			Montgon	•		
Funeral Director		5. Social Security Numberunk 6.	Sex 7. Age	(In yrs. last birthday) 40 Yrs	If Under Months	1 Year Days	If Under 24Hrs Hours Min.		th(MM/DD/YYYY	9. Birthr Foreign Coun		unk
ny	Ì	Usual Residence of Decedent  10a. State unk  10b. County	1-	10c. City, Town or Locat	ion					1- 1	0d Inside City	y Limits
Aaryland 28a-f show any 1 at once.	Ē	unk	unk						u		Yes 2	
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number		unk	10f. Zip C	Code		unk 1	0g. Citizen of Wh	at Countr	y?	unk
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rs after ural", miner	ò	Widowed 4 Divorce     Divorce  15. Decedent's Education (Specify)	ed If Yes, Give Year or Dates:	pleted) I 16a Deceder	Yes 2	No s	pecify:	unk vork done red) unk	Specify: 16b. Kind of Bu		hieter	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Cor	17. Father's Name (First, Middle, La	st)		unk	18.	Mother's Name	(First, Middle, I	Maiden Surname)	)		unk
	٤	19a. Informant's Name/Relationship	(Type, Print)		-	•			nber, City or Tow		Zip Code)	
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic	1	O.C.M.E.  20a. Method of Disposition		20b. Place of Dispos	sition (Name			altimor Date	e MD 2 20c. Location -	1201 City or To	own, State	
nore		1 Burial 2 Cremation			her place)							
Baltimore, permit Pages 1 ar Department of Her Important: If ite		21. Signature of Funeral Service Lice Rona U.S.	in stat	22. 1	Name and A			1 (55 1	. D 1		2.	
		23a. Par 1. Enter the disease, or co		I Ba	a I f 1 m o	TP.	MID 212	() (	7. Baltin		Street Approximate I	1000
Physician /Medical xaminer		failure List only one cause on	each line.  a. Multiple Injuries  Due to (or as a conse		The mode of	dying, su	cii as cardiac o	respiratory arr	est, snock, or nec		Between Ons Death	set and
		Sequentially list conditions,	b.	quence on.								
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):								
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60, tte be executed hysician and e burial - transit	Aedical	UNPENDED	AMENDED									
687 certifica		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	we l	2 Fe	etal death ther (Specif	3 <u> </u>	Ectopic pregna	nncy	23d. Date of Month	delivery Da	y Ye	ear
O. Bc t the dea by the a	Phys	Part II. Other significant condition	9 Unknown	but not resulting in the	underlvina c	ause give	en in Part I.	23e. Did to	obacco use contri	ibute to th	e cause of dea	ath?
, P.O. res that th signed by	<u>ج</u>		•	•				1 Ye	s 2 No 3	Proba	bly 4 Unk	known
of Vital Records, P.O. Box g Physician: The law requires that the death ther this certificate has been signed by the attenent director, page 2 should be detached for 1	Completed							24a. Was autop perfo 1  Yes	osy prmed? c		psy findings av mpletion of cau	
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of Vital   ng Physician: After this certif nneral director,	T E	examiner? 1 ✓ Yes 2 No		nt 2 🗸 ER/Outpatient		· ·		g Home 5	Residence 6	Other:		
	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investig		28b. Time of 0000 hrs	Injury 28	3c. Injury a	E -		how injury occurr struck by aut			
Division pital or Attendion ours after death. teral Director: /	Certification:	3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of Inj	ury - At home, farm, stre or Road / Highway		office buil			Street and Numb State) University Blv			er, City
D To the Hospital within 24 hours: To the Funeral	Medical		ner:On the basis of exan	knowledge, death occu nination and/or investiga								
To To cor	Me	29b. Signature and title of certifier	and manner stated.		29c.	License r	number		29d. Date sign		h, Day, Year)	
		linat 2	<del></del>			O.C.M.	E		August 23,	2010		
		30. Name and address of person what Ana Rubio MD. Assis	o completed cause of detant Medical Exam	, ,	Street Ra	altimore	e. MD 2120	1				
	tate	31. Date filed (Month, Day Year) SEP 1 4 2010		10.01.101.11			., 1110 2 120					
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			State State	of Maryland / D	epartment of H			2011	28680	
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	Examin		4a. Facility Name (If not institution, give street and	- 4	4b. City, Town, or	Location of Death		4c. County of Deat	200	
4			5. Social Security Number 6. Sex	XSIDE  7. Age (In yrs. last birth	DEL	If Under 24 Hrs. 8	. Date of Birth	9. Birt	thplace (State or Foreign	
	Funeral Director		156-20-5540 1□ M 2 1 1 1 M 2 1 1 1 1 1 1 1 1 1 1 1 1 1		Yrs. Months Days	Hours Min.	(Month, Day, Yes	ar) Co	wintry) W Jersey	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits	
Baltimore, Maryland 21215-0036	Maryii i-f sho iied al	ţ		Bel A	ir				1 □Yes 2 XNo	
	or 28a	Director	Maryland Harford  10e. Street and Number	DELA	10f. Zip Code		10g.	Citizen of What Co	ountry?	
	s 23a		636 Lochern Terrace			leader to October 200 (October 1	fu Va a ou Na	USA	vice a leading	
	fter de ritem irer r	Funeral	1 Never Married 2 Married 1 □ Ye	Forces?		n, Mexican, Puerto Ric	can, etc.)	14. Race - Ame Black, White		
	iral",o	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Year o	Give or Dates:	1 □Yes 2XINo	Specify:			nite	
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	ed dal	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (				
<u> </u>	nd 2 should alth and Mer 27 Is marke r traumatic	ဥ					et Elizabeth Green			
<u>B</u>			19a. Informant's Name/Relationship (Type. Print)  19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  636 Lochern Terrace, Bel Air, MD 21015							
ore,	ges 1 and 2: It of Health a It item 27 Is or other trai		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal fro	20b. Place of	Disposition (Name of y, crematory or other place			. Location - City or	Town, State	
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g B	permit. Page Department of Important: If any Injury or once.		21. Signature of Fune A Service Licensee  22. Name and Address of Facility McComas Funeral Home, P.A.  1317 Cokesbury Road, Abingdon, MD 21009							
	Physician		23a. Part 1. Enter the disease, or consist that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between							
40.00			Immediate Cause (Final disease or condition resulting in death)  Onset and Death							
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		Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
8760,		dical E	d d							
89	rtificate ng phys as the	<b>Jedic</b>	U							
XOX	death certifics e attending ph ed for use as tt	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy					23d. Date of delivery  Month Day Year		
	2 0 0	ysic	1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown			Other (specify)				
ທຸ ກຸ່	The law requires that the disternance has been signed by the sage 2 should be detached	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?			
g	equire sen siç ould b	ted t	Denesta Anemia				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown			
Vital Records,	e law i has b je 2 sh	Completed					24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?			
			25. Was case referred to medical			26. Place of Death (	1 □ Yes 2 N	lNo 1 □Yes	s 2 No	
=	nysicla nis cer direct	o Be							ecify)	
Division of	ling Pt After th uneral	ion:								
1810	io the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, far			f. Location (Stree	t and Number or R	ural Route Number,	
2		Certification: To	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)							
		edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		Med	29b. Signature and title of certifier 29c. License number				29d.	29d. Date signed (Month, Day, Year)		
			) (W)	//whi n	m $D2$	7975		9/12/10	)	
	lev		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NOWN MUME M 6/T Max Phil M Bet Are. Mn 2101V							
	Sta Registi			2. Register's Signature	1 (2.0)		1 10	1010	(	
	negisti	rell	SFP 1 4 2010	Three B	· Marke					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ a PTEMA! Medical 4c. County of Death Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMOPE >16 CHRIS ALTIMORE enter 8. Date of Birth (Month, Day, Feb. 18 7. Age (In vrs. last birthday, 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Hours 1 🗆 M 2 💢 F 1949 **Director** 61 134-38-4459 Korea Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 Korea 7526 Baleen Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces 1 Yes 2 No If Yes, Give Year or Dates. Ş 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Korean Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Yi-chun Cha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7526Baleen Court, Glen Burnie, Maryland21061 Richard Curl/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, Inc.9-13-10 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG Physician/ MASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to or as a consumence of If any leading to in medicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last use as the bunal-transit attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? δ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes completed filled in by the funeral director, 25. Was case referred to -dical 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 2 **N**o ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred atural injury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🔲 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of

Registrar
DHMH 17 Rev 7/2009

State

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 10,2010 4:30 A Calo September Gustave Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Stella Maris Hospice 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Hours Min Country) Months 1 🕅 M 2 🗆 F 217-22-0556 September 21 ,1928 Maryland 81 Director Usual Residence of Decedent 10d. Inside City Limits shov 10a State 10b. County 10c. City, Town or Location with the Maryland Director r 28a-f s notified 1 Yes 2 X No Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō must be r Funeral 21222 USA 7242 Martell Avenue hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? a.⊞. 11. Marital Status Examiner ò ģ 1 Never Married 2 Married X Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No White Specify: "natural" Completed 3√ Widowed 4 Divorced Year or Dates and Mental Hygiene.

is marked other than "natural aumatic event, the Medical. 15 Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 72 h Health and Mental Hvoiene College (1-4 or 5+) Elementary/Seconday (0-12) Baltimore City Firefighter 8 vears Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ၉ Marie Elizabeth Lovell John Benjamin Calo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 4611 East Joppa Road, Perry Hall, Maryland Deborah Button Daughter SEPTEMBER 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition September 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
. Stanislaus Cem. St. Baltimore, Maryland 13, 2010 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of 7110 Sollers Point Road, Dundalk, P.A. Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on. or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death the g Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA မူ 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera 1 X Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of try knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie em ben

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

21128

Year

10h 2010

DHMH 17 Rev 7/2009

State

Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

acks

32. Registrar's aignature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT, MD

31. Date filed (Month, Day, Year)

SEP 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 9/14/2010 Physician/ 12:10 A<sup>M</sup> Susan Elizabeth Deithorn Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Airy 5353 Buffalo Rd. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, Year) 7/4/1965 Min. Country) 1 M 2 XF 234-90-4581 45 **Director** Usual Residence of Decedent or 28a-f show a notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 Yes 2XXNo Carrol1 Mt. Airy MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a or edical Examiner must be Funeral USA 5353 Buffalo Rd. 21771 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natur ury or other traumatic event, the Medical Eury or other traumatic event and the medical Eury or other traumatic event 16a. Decedent's Usual Occupation 16b, Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Long & Foster Real Estate Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Glenna Hudson Chester Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5353 Buffalo Rd., Mt. Airy, MD 21771 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Shane Deithorn/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 17/2010 4 Donation 5 Other (Specify) Mt. Airy, MD Pine Grove Cemetery Signature of Euporal Service 22. Burrier Oueen Funeral Home & Crematory, P.A. orlly 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death PANCREATIC CANCER Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate Examine Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed notes after death.

1.24 hours after death.

e Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) completed filled in by the funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 7/2009

State

Registrar

within 2 To the I

29b. Signature and title o

31. Date filed (Month, Day, Year)

4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SADAF TATMUR 46B Thomas

32. Registrar's Signature

3 Cartifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Thomas Johnson

29c. License number

D-2.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Marrie E. Dowell 10:00 2010 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Keswick Nursing Home Social Security Number 7. Age (In yrs. last birthday) 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 1 🗆 M 2 💢 F Director 4-3-1927 214-22-7561 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner ministration. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No n/a Baltimore M) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 340<u>7 Park Heights Avenue</u> 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 1 ☐ Yes 2 XNo Specify: Specify: African-American 3 ▼Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Franklin Square Hospital Operating Room Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bessie M. Carter Willie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2538 Park Heights Terr., Baltimore, MD 21215 Yvonne Dowell/ Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-17-2010 Baltimore National Cen Catonsville, MD 21. Signatur) of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part/1. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final BILAterAL Physician/ recks m disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a conseque resulting in death) Last Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Records, 2 1 No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed certificate 1 Yes 2 No Trop.... 24 hours after deatn. e Funeral Director; After this certifica ∵ ⊤alled in by the funeral director, f Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Investigation
6 Could not be 1 ☐ Yes 2 ☐ No Accident within 24 hours after deg

To the Funeral Director

completed filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

State

30. Name and address of

31. Date filed (Month, Day, Year)

SFP 14 2010

person who completed cause

death (Item 23a) (Type, Print)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Of Marylan		tificate of D			Reg. No.2	010	28685		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month Septemb		Year	3. Time of Death		
	Medic	al .	Evelyn Elizabeth DiPietro  4a. Facility Name (if not institution, give street and number)		4h City Tayan and	Leasting of Dooth	Septemb		2010 ounty of Death	1:55am <sup>M</sup>		
	Examin	er	Dove House		4b. City, Town, or I			Carrol1				
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. Birthplace (State or Foreign				
	Director		214-03-7389 <sup>1□м2</sup> 1□м2  1□ M2  1□	Yrs.	Months Days	Hours Min.	7-19-19	19	Mary	land		
	d at	١	Usual Residence of Decedent           10a, State         10b. County         10c. Cit	ty, Town or Loc	cation				1	0d. Inside City Limits		
	arylar a-f sk fied a	ecto		isterst						1 ☐ Yes 2 🛣 No		
	or 28 e noti	ă	10e. Street and Number	LSCCISC	10f. Zip Code			10g. Citize	n of What Cour	ntry?		
	s 23a rust b	Funeral Director	444 Main Street		21136			Unite	d State	s		
	death item ner m		11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. W	Vas Decedent of His Yes, specify Cuban	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Americ Black, White,			
036	ould be filed within 72 hours after death with the Maryland Montal Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.		☐ Yes 2X No			Sp		hite		
Maryland 21215-0036	72 hou an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	[ (Give k	lent's Usual Occupa kind of work done du O NOT use retired)		ing	16b. Kind	of Business Inc	dustry		
212	within giene. er tha , the I		Elementary/Seconday (0-12) College (1-4 or 5+) 8 years	Manag	er			Murr	y Clean	ers		
nd	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam						
<u>₹</u>	uld be 1 Men narke natic	-	Earl W. Zentz					tinge				
<u>≅</u>	2 should th and Me 27 is marl traumati		19a. Informant's Name/Relationship (Type, Print)  Charles E. Murray (Nephew)		ig Address (Street at Lyndon Tr							
	F Heal		20a, Method of Disposition 20b. F	Place of Dispos	sition (Name of		Date		ation - City or To			
E O	Page 1 ment of ant: If if ury or o		E-Burial 2 Li Cremation 3 Li hemoval nom State		natory or other place Mem. Gar		-2010	Finks	burg, M	laryland		
Baltimore,	permit. Page Department Important: It any injury or once.		21. Signature of Fundral Service Licensee		. Name and Address		LINE FU					
<u>m</u>	e a E E e		JAFX 13 EL		824 Reist				town, M	D 21136		
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not ente	Land Control	1		rest,		Approximate Interval Between Onset and Death		
-	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	e	Hem	DMagh			-	Short and Doday		
	Examiner		Due to (or as a conseq	ruence of):	a Mai	cular	acc	ralo	net			
		ner	Security list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of the cause.									
	outed nd ransit	Examiner	Cause (Disease or linjury that initiated events									
	e exec sian al urial-t	al E	resulting in death) Last . Due to (or as a conseq	uence of):								
760	icate be executed g physician and s the burial-transit	<b>Nedical</b>	d									
89	.2 50	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant	ancy	1			23	d. Date of deliver	ery		
Box	death certif ne attending ed for use a	Physician/N	in the past 12 mont s?  1  Yes 2 No 4 Pregnant at time of		Other (specify)	У			Month	Day Year		
P.O.	t the c by the tache	Phys	g □ Unknown	14: :- 41		en in David	00 011			he cause of death?		
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ord	5 0001	Completed					24a. Was			psy findings available impletion of cause of		
Rec	sician: The law certificate has lirector, page 2 :	Som					_ perfo	ormed?	death?	_ /		
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?		T.	ace of Death (Chec	k only one)			3		
Š	Physic this cal dire	<u>1</u>	1 Yes 2 No Prospital 1 Inpatient 2 2 27. Manner eath 28a. Date of injury	ER/Outpatien		4 ∐ Nursing H	ome 5 Resident			House		
0 0	ding Ph th. After thi funeral	cate	1 atural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work		26d. Describe I	iow injury o	ccurred	1,000		
Division of Vital Records,	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificated filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Specif		eet, factory, office		28f. Location (S		Number or Rura	l Route Number,		
Š	pital or ours aft eral Dir filled in									-		
	To the Hospital within 24 hours To the Funeral completed filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my know (Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my know only one) 3 Certifying Nurse Practioner:	on and/or invest	tigation, in my opinio	n, death occurred a	it the time, date a	and place, a	nd due to the ca	use(s) and manner stated.		
	Vithi Comp		29b. Signature and title a certifier	10	29c. License	number 543	18	29d. Date	signed (Month,	Day, Year)		
			20. Name and Politices of person who completed arises of state. (Inc.	m 28a) (Time F	Print - A	~ ~		00	13.	- 2010 1 MD		
	161		30 Name and address of person who completed cause of death (Iter	349	Pringhaleal	m Di	m, W	entr	Winster	1177		
	Stat Registra		SEP 1 4 2010 32. Registrar's Signa	ature						1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Day, Physician/ 6:30 AM September 2010 01ga DiGalbo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Social Security Number Age (In vrs. last birthday) 1 □ M 2 🕅 F New Jersey March Day 3 Year 920 Director 90 138-01-2725 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛱 No Maryland Baltimore Phoenix 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21131 14112 Jarrettsville Pike 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Pharmaceutial 12 Bookkeeper n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hazuda Helen Lajkun John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14112 Jarrettsville Pike, Phoenix, MD Dennis J. DiGalbo/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State Denation 5 Other (Specify 9/11/10 Glen Burnie, Maryland Atlantic Crematory Lemmon Funeral Home of Dulaney Valley Inc 10 W. Padonia Road, Timonium, Maryland 2 21093 Enter the disease, or complications that or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Iterval Betweer Immediate Cause (Final set and Death Physician/ disease or condition Medical resulting in death) Due to (o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Dav Year been signed by the should be detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 2 No After this certificate 1 Yes Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Hospital: Other: 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Dutpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 ☐ Yes 2 ☐ No 2 🖸 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2<u>010</u> Physician/ Month 6:35 AM M August Frank H. Dorsey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Blue Point Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Feborin 8 ay, Mary Tand Director 79 213-26-9504 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 2525 W. Belvedere Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. black Specify: 3 DWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) janitorial maintenance 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edna Dorsey Frank H. Dorsey Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3836 Sequoia Avenue Baltimore, MD 21215 19a. Informant's Name/Relationship (Type, Print) Phyllis Dorsey/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 💢 Other (Specify) in state FRANK signature of Funeral Service Licensee RODE d S Wade <sup>22</sup> Name and Address of Facility Board 655 W. Baltimore Street \*rector 23a. Pvt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line.

Immediate Suse (Final disease or confilt in resulting in death)

a. Due to final a consequence of: Interval Between Onset and Death Physician/ ininuco Medical Due to ( as a consequence of): Examiner heart disease theroscierotic Sequentially list ou iditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): His pertension attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last onyestive heart Julye Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be def Completed by chesit Ch either Fibrillahl 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner?
1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manger of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Get hymner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

DESA! M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signa

DCRSE

D304014

216 maiden Cherce lane Colonsville moviles

29d. Date signed (Month, Day, Year)

8 130/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year ZOIO Physician/ Maxine 16100 AM W Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Annapolis Arundel enter Anne 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min May 7, 1953 1 - M 2 X Mary land Yrs 212-64-5212 57 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file and Mental Hygiene. and the file and 275 is marked of other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2x No MD Charles Waldorf 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20602 1609 Boarman Court USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1.2 College (1-4 or 5+) director answering service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald Linwood Morgal Ralene Kordick Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20602 1609 Boarman Court Waldorf, MDKristan Parks/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If i
any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) Signature of Euneral Sarvice Licensee Wade State Anatomy Board 655 W. Baltimore Street frector 22 MDEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorrha disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? been signed by the atte Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown **Ves** Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform certificate 2 No 1 Yes 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပု operient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this Date of injury (Month, Day, Year) the funeral . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Cheok only or 29b. Sign and title o 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30 Nar

oitali

eted cause of death (Item 23a) (Type, Print)

H005Z021

Parkwa

Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	Maryland / De			viental Hyg	giene 0 1 0	28689
		ľ	1 - State Registrar		Certificate of E	Death		leg. No.	
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	Day Year	3. Time of Death
	/Medic	_	Elizabeth A. Degnan		4b. City, Town, or	Location of Death	Depter	4c. County of Deatl	
5	Examin	er	4a. Facility Name (If not institution, give street and num			2NSVI	10	Bc 17	more
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	fay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. Birtl	hplace (State or Foreign
	Director		212-03-6514	91 Yrs	s. Months Days	Hours Min.	Aug. II	, 1919 Ma	ryland
	pr ,		Usual Residence of Decedent	10c. City, Town o	ar Location				10d. Inside City Limits
	arylar show	-	10a. State   10b. County	Toc. City, Town o	Catonsvi]	110			1 □Yes X□ No
	the M	Director	10e, Street and Number		10f. Zip Code	LIE		10g. Citizen of What Co	untry?
	with la or t be r	ä	719 Maiden Choice Lane,	127 South	212	228		United S	-
	ms 20	Funeral	11 Marital Status 12. Was Dece	dent Ever in U.S.	13. Was Decedent of His If Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No	14. Race - Ame	
0	after o		Armed For  1 Never Married 2 Married 1 Yes, Giv.	2[ <b>X</b> No	1 ☐ Yes 2 ☒ No	n, mexican, Puero Specify:	o rican, etc.)		hite
2	ours a	d by	3 ☐ Widowed 4 ☐ Divorced Year or Da	ites:				op dony.	
ה	72 h "natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occupa Give kind of work done d ife. DO NOT use retired,	ation <i>luring most of wor</i> '	king	16b. Kind of Business/	Industry
V	within	E E	Elementary/Secondary (0-12) College (1-12)	4or 5+)	Homemaker	,		Own	Home
7	filled v Hygie ther i		17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
o o	ld be ental ked o ic eve	To Be	Joseph Degnan			Mai	rgaret M	cMahon	
ary	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural"; or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street a	and Number or Ru	ıral Route Numb	er, City or Town, State, 2	Zip Code)
≥	and 2 salth a n 27 ls	1 6	Norman Waltjen - Bro.			vood Clui		utherville,	
ore	of He		20a. Method of Disposition  1 □ Burial 2 ▼ Cremation 3 □ Removal from 9		Disposition (Name of crematory or other place		Date	20c. Location - City or	
Ē	Pag tment tant: jury c	/	4 □Conation 5 □ Other (Specify)	Atlant	cic Cremator	9	-2010	Glen Burni	
pallimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	(	21. Signature of Funeral Service Licenses	1540	22. Name and Addres			Funeral Hom rbutus, MD	-
UN			P. ff. Enter the disease, or complications that or shock, or heart failure. List only one cause on ea	aused the death. Do no					Approximate
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-	Physician /Medical		disease or condition resulting in death) a. Due to (	or as a consequency f)	gemen	TIA			years_
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	p #	iner	cause. Enter Underlying	or as a consequence of)	):				
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Vitai	'sician: The law s certificate has E lirector, page 2 s	Be	25. Was case referred to medical examiner?  Hospital:		ostiont 3D DOA Othe	or:	ath (Check only		
0	Phys r this ral dii		27. Manner of Death 28a. Date	npatient 2 ☐ ER/Outp of Injury 28b. Tir	allerit S DOA	4 <del>LI N</del> ursing F	1	dence 6 Other (Spe	ecity)
O	ding h. : Afte	tion	1 ⊟Natural 5 □ Pending (Mont 2 □ Accident investigation	th, Day Year) Inj		k? Yes 2 ⊟No			
UIVISION	Atter	ifica	C C Could not be	of injury - At home, farn ng, etc. <i>(Specify)</i>	n, street, factory, office			Street and Number or R wn, State)	tural Route Number,
5	tal or s afte al Dir ed in	Certification:	- Julian				0.0, 0.70		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, and the funeral director	edical (	29a. Certifier (Check only  1 ☐ Certifying Physician: To the 2 ☐ Medical Examiner: On the box	asis of examination and					
	thin 2.	Medi	one) and mani	ner stated.	29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
7	<b>7</b> ≥ ₹ 8		111182	am	Du	7000		_	
7	n		30. Name and address of person who completed caus	e of death (Item 23a) /T	vpe, Print)	1001		Septemb	er 1, 2010
	2		Phillip Stone 7	11 Maide	n Choice	e Lane	Balt	imore MI	21228
	Sta	ate	31. Date filed (Month, Day Year) 32. R	egistrar's Signature			/		
	Regist	rar	CCD 3 4 2010	1 hours	29				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, 28690 State of Marylahod, Berartinghoof Health and Mental Hygiene 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death S & Month Year 06:30 AM Deborah Irene Evans 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown Seasons Hospice@Northwest Hospital Center Baltimore 5. Social Security Number If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month Day, NOV • 5 9. Birthplace (State or Foreign 4962 Mary Tand 217-86-6487 47 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits YYYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Woodbine Avenue 21207 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 12 grade (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Evans Nona Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nona Worma Evans/Mother 3734 Beehler Ave. Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 9/18/2010 King Memorial Park Woodlawn, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore,MD 21215 ans 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Cancel se or condition VICAV resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause Disease or i Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 9 Unknown 9 Unknown

Physician/ Medical Examiner Examine

Physician/

Medical

10a. State

Director

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**Examiner** 

**Funeral** 

Director

shov or 28a-f shov notified at

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permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiane.
Important: If them 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be.

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Medical Certificate: To Be filled in by the completed

Hospital or Attending Physician: The law requires that the death certificate be executed

24 hours after deat Funeral Director:

Division of Vital Records, P.O. Box 68760

Part II. Other significant conditions	ontributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
			1 Yes 2 No 3 Probably 4 Junknown
			24a. Was an autopsy performed?  1 □ Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 No
25. Was case referred to medical examiner?		26. Place of Death (Chec	k only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Other: 4 Nursing Ho	ome 5 Residence 6 Kother (Specify) Inft Holm
27. Manner of Death  1	' I		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 \(\sumeq\) Medical Exam	ner: On the best of my knowledge, death occu	ion, in my opinion, death occurred a	t the time, date and place, and due to the cause(s) and manner state

74013

6934 Aviation Blud 21061

29d. Date signed (Month, Day, Year) Septembro 12,2010

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

barm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-07012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Fabian, III		I- For State Registrar	State	of Maryla		artment o ertificate o	f Health ar f Death	d Mental		Reg. No.	201	28691
Physiciar Medical Examin	1/	1. Decedent's Name John	e (First, Middle,La	st) Fabian	111				2. Date of De Month Septemb	eath Day	Year 2010	3. Time of Death 2345 hrs
		4a. Facility Name (if Solley Road			umber)		4b. City, Town, o Glen Burni		eath		: County of Dea Anne Arunde	
Funeral Director		5. Social Security No. 217-17575		Sex XM 2 F				rs Hours	Min.	te of Birth(MM/DD/YYYY) 9. Birthplace (State Foreign 7/01/1976 Country) MD		
d how any		Usual Residence of 10a. State 1 Mary land	10b. County	Arunde.	1 '	, Town or Locat	ion	len Bur			<u> </u>	10d. Inside City Limits  1 Yes 2 X No
the Marylan a or 28a-f s	Director	10e. Street and Num 207 Ceda:	nber	TIT direct	<u> </u>		10f. Zip Code	21060	lite	10g. Citi	zen of What Co US A	untry?
or items 23	Funeral	11. Marital Status 1 X Never Married		d Armed Fe	2 X No		es, specify Cuba	n, Mexican, Pu	( Specify Yes or Nerto Rican, etc.)	lo-	White, etc.	rican Indian, Black,
2 hours afte "natural",   Examiner	⋧┞	Widowed  15. Decedent's Edu  Elementary/Secon	ucation (Specify	d If Yes, Give Yea or Dates: only highest grad College (1	de completed)		Yes 2 No nt's Usual Occupa lost of working life	tion (Give kind		16b. F	Specify: Kind of Business	White //Industry
21215-0036 Juld be filed within 7 Mental Hygiene. mental other than event, the Medica	Be Completed	12 17. Father's Name (F Michael		t) Fabi	an Sr.		Mechan		ame (First, Middle	, Maiden	_	nt
MD 215 ad 2 should be alth and Men m 27 is marl aumatic eve	<u>•</u> [	19a. Informant's Nan Janet L.	Fabian	Type, Print) (moth	ıer)	19b. <b>M</b> ailing	Cedar Dı	et and Number	or Rural Route Nu len Burn.	ie, i	ity or Town, Stat MD 2106	0
Baltimore, MD permit Pages I and 2 sho Departer of Heralth and Infortants of Heralth and Importants of Historical Information of Information			Cremation 3 Other Specifi	y:	om State	crematory or ot tro Crei	matory I	nc. S	Date ept. 20 2010	Ва		, Maryland
Physician		23a. Part I. Enter the	2	The state of	aused the death			intain	Road, Pas	sade	na, MD :	Home, P.A. 21122 Approximate Interval
/Medical Examiner		failure. List only Immediate Cause (F or condition resulting		Multiple Inju	uries consequence o	of):						Between Onset and Death
		Sequentially list condi if any, leading to imn cause. Enter Underl	nediate lying Cause	Due to (or as a	consequence of	of):			<u></u>			
ed nsit	Ž	(Disease or injury the events resulting in de		•	consequence o	of):						
760, cate be exception physician the burial	Medical	F FEMALE:	respect in the	AMENDED 23c. If yes, o	outcome of preg	nancy				230	d. Date of deliver	у
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedieved of Certification: To De Computed the Direction of the control of the cont	nysiciar	3b. Was decedent p past 12 months? 1 Yes 2 No	o 9 🗌 Unknow	n 9 Unkno	ant at time of de	eath 5 Ot	tal death 3 her <i>(Specify)</i>	Ectopic pre	egnancy		Month	Day Year
ls, P.O. quires that the en signed by alld be detach	2	Part II. Other signifi	cant conditions	contributing to	death but not r	esulting in the u	nderlying cause (	given in Part I.		es 2 🗸	No 3 Pro	
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/ital	ון מ	25. Was case referre examiner?  1 ✓ Yes 2		Hospital: 1	npatient 2	ER/Outpatient		of Death (Che	rsing Home 5	Reside	nce 6 🗸 Othe	er: Scene
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached confined for the funeral director.		27. Manner of Death		28a. Date (Month, Sep 11,		28b. Time of It		ry at Work? ∕es 2 ✓ No	28d. Describe Motorcycle		ry occurred collided v	vith car
Division o spiral or Attending nours after death eneral Director: Aft filled in by the fune		4 Homicide	6 Could not determine	De		ome, farm, stree d / Highway	et, factory, office b	uilding, etc.	or Town,	State)		ural Route Number, City d, Glen Burnie, Md.
Divisior  To the Hospital or Attend within 24 hours after death of the Funeral Director: completely filled in by the		one) 2 🗸 N	Medical Examine		of examination a		ion, in my opinion	, death occurre	and due to the cau ed at the time, date	and pla	ce, and due to ti	ne cause(s)
		29b Signature and ti	Dre K	nele			29c. Licens O.C.I				Date signed (Mo tember 12, 2	
		Margarita Ko	rell MD. A	ssistant Med	lical Examir	ner 111 Po	enn Street, B	altimore, M	D 21201			
Stat Registra	Y.,	31. Date filed (Month,	, Day, Year)	32. Re	gistrar's Signati	A e	<u> </u>					
DHMH 17 Rev 1/200 OCME 2006	1	OLI I	* 2010	Central	10. 1	ORIGINA					0(	OME

DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medio		Margaret	El	izal	beth	Fr	etei	r					Month Septem		12,	2010	5:30am	М	
Examin		4a. Facility Name (if		, give st	reet and nun	nber)			4b. Cit	y, Town, or	Location of					of Death			
		205 S1ade 5. Social Security Nu		6. Sex		7 Ago (le	n ura lar	st birthday)		Pikesville If Under 1 Year I If Under 24 Hrs.   8 Date of Bir					Ba1	timor			
Funeral Director		214-18-65			M 2 <b>X</b> F	7. Age (ii	-	Yrs.	Months		Hours	Min.	(Month, E	(Month, Day, Year) Cor			place (State or For htry) [arvland	reign	
T om		Usual Residence of 10a, State	Decedent 10b. County					T 1					0 17	1721					
arylan a-f sh fied a	Director		Balti	m 0 14				Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ※ No				
or 28 e noti		Maryland 10e. Street and Num		HOLE	<u> </u>			Pikesv		ip Code				10g. C	10g. Citizen of What Country?				
s 23a nust b	Funeral	205 Slade	Ave.						2	1208				Un	ited	Stat	es		
death r item iner n		11. Marital Status		- 1	2. Was Dece Armed Fo 1 ☐ Yes	edent Ever	r in U.S.	13. V	Vas Dece Yes, spe	edent of Hi ecify Cuba	ispanic Origi n, Mexican,	n? (Spe Puerto	cify Yes or No Rican, etc.)		14. Rad		can Indian,		
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and 2 Health em 27 ther tr		Eileen Fr 20a. Method of Disp		daug	hter)					**	l. Lut		ville,						
age 1 and of 1 trint o		1 🔀 Burial 2 🛭	Cremation	3 🗆 R	emoval from	State	tate cemetery, crematory or other place)							20c. Location - City or Town, State					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation  21. Signature of Fun				Į,	nooa				s of Facility	-15-	-2010	Woo	odlav	m, M	D	-	
Dep lang		21. Signature of funeral Sarvice Licensee  J. Wayne Osterling 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstow										own,	MD 21136						
		23a. La 1 1. Enter th shock, or hear	ne disease, or Llailure. List d	complic	ations that o	aused the	e death.	Do not ente	r the mo	de of dying	g, such as ca	ardiac o	r respiratory a	arrest,			Approximate Interval Between	n	
hysician/ Medical	9	Immediate Cause (F disease or condition resulting in death)		a.	Ch	-0-			sta	ucti	12	LU,	~ /	) - ( @	- 65 4		Onset and Death	1	
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hat the ed by detach		Part II. Other signifi	cant condition	ns cont	ributing to d	eath but r	not resul	Iting in the u	nderlying	cause giv	en in Part I.		23e. Did	tobacco	use cont	ribute to th	ne cause of death?	?	
uires t n sign uld be	ed by												1 🗆	Yes 2	? □ No	3 Pro	bably 4 🗆 Unkn	nown	
aw req as bee 2 shou	Completed												24a. Was	s an opsy			psy findings availa mpletion of cause		
The Is cate ha	Con												per	formed?		death? 1  Yes			
sician: certifi rector,	Be o	25. Was case referre examiner?  1  Yes 2	_	Но	spital:	-				Othe	ace of Death								
g Physer this eral di	e: To	27. Manner of Death			28a. Date	of injury	2	R/Outpatien 8b. Time of		OOA   28c. Injury	4 ∐ Nurs		me 5 Res				)	_	
ending sath. or: Afti he fun	ficat	1 Natural 2 Accident 3 Suicide	5 Pendin	gation	(IVION	h, Day, Ye	ear)	injury	М	work	? Yes 2 🗆 N	lo							
of the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	4 Homicide	6 ∐ Could determ			of Injury - ng, etc. <i>(</i> S		ne, farm, stre	et, facto	ry, office		2	28f. Location City or To			er or Rurai	Route Number,		
spital hours a neral I	Medical	29a. Certifier	Certifying	Physici	ian: To the b	est of my	knowled	dge, death o	ccured a	t the time,	date and pla	ace, and	d due to the c	ause(s) a	nd mann	er as state	ed.	-	
the Ho nin 24 I the Fu npleter	Med	only one) 3	□ Certifying	xamine Nurse f	r: On the bas Practioner:	is of exam To the bes	nination a t of my l	and/or investi knowledge, d	gation, in eath occi	my opiniourred at the	n, death occu time, date a	urred at nd place	the time, date e, and due to t	and plac he cause	e, and du (s) and ma	e to the ca anner as st	use(s) and manner s ated.	stated.	
with Con To I		29b. Signature and ti	itle of certifier						29	c. License	number			29d. Da	ate signe	d (Month,	Day, Year)		
		30. Name and addres	sshi naroan	who com	inleted cours	e of doot	h (Itam 1	(Sa) (Tupo D	rint)	02	908	-5		Se	210	mar ,	. 13 20	110	
QV		Allen	J- 0			o oi ueatr	5 (meni 2	S I C	rint)	10	Cou.	-+	Renan			2	5211		
Stat	е	31. Date filed (Month	42010			egistra	Signat	arke											
Registra	II.			/			. /												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8<sup>Day</sup> Sept 20**10**" Physician/ 11:00 a.<sup>™</sup> Dolores Glover Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Owings Mills 3420 Associated Way, Apt. 404 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Days SC 069-30-7291 71 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show | Hygiene. | other than "natural", or items 23a or zoo-. .... 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Owings Mills Baltimore MD 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21117 3420 Associated Way, Apt. 404 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 1 Tes 2 No Specify. If Yes, Give Year or Dates Specify African-American 3 - Widowed 4 Divorced Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Long Island Elementary/Seconday (0-12) College (1-4 or 5+) Developmental Center 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H Minnie Washington ည Johnny Glover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9202 Leahs Lane, Owings Mills, MD 2111.7 19a. Informant's Name/Relationship (Type, Print) Bruce Glover Sr. /Son 1 and 2 s if Health permit. Page 1 to Department of He Important: If itemany inima 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 Cremation 3 Removal from State 9-15-2010 Woodalwn, MD Woodlawn Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral. Home P.A. of Baltimore Co. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, Maryland 21133 Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Colon Cancer Immediate Cause (Final Metastatic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): mouth **Examiner** olon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? pertension 24a. Was an autopsy performed? Yes 2 X No cate has page 2 s 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Box 68760 P.0. Division of Vital

Baltimore, Maryland 21215-0036

Medical 29d. Date signed (Month, Day, Year) 29b. Signatate and title of certifier alo D 0038041 4W ROLLING CROSS ROADS 1100, BALTIMORE MD 21228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUGHIRA THAKOR, MU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Barker Registrar

only one)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For	State of Ma	aryland / Depa			Mental Hyg		00001	
			State Registrar		Cer	tificate of L	Death	F	Reg. No 2010	28694	
п	Physicia	n/	Decedent's Name (First, Middle	,				2. Date of Dear Month	th Day Year	3. Time of Death	
Ц.	Medic	al	Darren 4a. Facility Name (if not institution,	Dwayn	ie	Green	r Location of Death	109	98 2010		
,,,,,,,,	Examin	er							4c. County of De		
	Funeral		Summit Park N  5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year		8. Date of Birth			
	Director	9	215-86-1932	1 <b>X</b> □ M 2 □ F	Yrs.	Months Days	Hours Min.	(Month, Day,		Country) M.D.	
	nd how at	ŗ	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Loc	eation				10d. Inside City Limits	
	larylar 3a-f s ified	Director	MD Balt	imore		nsville				1 ☐ Yes 2 🔀 No	
	the N or 28		10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?	
	s 23a	Funeral	12 Rambling C	ak Wav Apt	. D	212	28		U.S.	4 -	
	death r item ner n		11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13. V	Vas Decedent of H Yes, specify Cuba			14. Race - An Black, Wh	nerican Indian,	
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Be Completed by	1 Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No 1	☐ Yes 2 ☐ No	Specify:			Black	
21215-0036	hours natur lical E	lete	15. Deceder	Year or Dates.		ent's Usual Occup			16b. Kind of Busines	s Industry	
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Maryland	be filed ental Hy ked oth ic event	,0	17. Father's Name (First, Middle, L	ast)				ne (First, Middle, N	,		
Ĭ	should be and Me		John Green 19a. Informant's Name/Relationsh	nin (Typa, Print)	140, 14, 35	A.I.I. (O) /		1 Spive			
	12 shullth ar 27 is r trau		Andrea Long-S							Zip Code) 21228 sville, Md	
re,	1 and 2 soft Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispos	sition (Name of			20c. Location - City		
altimore,	Page nent o ant: If ury or		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State pecify)		natory or other place Memori		9/15/1	lO Arbuti	ıs. Md	
Salt	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Funeral Service L	icensee	22	. Name and Addres	ss of Facility				
Ω	0 0 <b>5 € 0</b>		Sola IVI	arch	14.	<u>300 Wab</u>	<u>ash Ave</u>		more, Mo	21215	
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that caused nly one cause on each line.						Approximate Interval Between	
	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	ACQUIR	consequence of):	UNE DE	FICIENC	7 SYND	20200	Onset and Death	
	Examiner				STING 5						
-		iner	Sequentially list conditions, if any, leading to immediate	b. —	consequence ot):	11-100					
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	ate be executed physician and the burial-transit	al E	resulting in death) Last	Due to (or as a	consequence of):						
760	ate by physic the b	edical		d							
89	eath certifica attending ph for use as th	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	of pregnancy				23d. Date of c	lalivon	
Box 687	eath of atter	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		Ectopic pregnand Other (specify)	У		Month Month	Day Year	
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rds	v requires been sig should b	eted						1 ∐ Y	es 2 No 3 No	Probably 4 Unknown	
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Ä	Physician: The lav r this certificate haveral director, page 2		25. Was case referred to medical					1 🗆 Yes		es 2 No NA	
/ita	sicial certi	To Be	examiner?	Hospital:	nt 2 🗒 ER/Outpatien	Otho	ace of Death (Chec				
of/	g Phy er this neral o	te: T	27. Manner of Death	28a. Date of injury	y 28b. Time of	28c. Injury	y at		ence 6 Other (Spensor injury occurred	ecify)	
on	endin sath. or; Aft	ficat	1 Natural 5 Pendin 2 Accident Investig	ation	Year) injury	M 1 □	:? Yes 2 ☐ No				
Division of Vital Records,	or Atte	Certificate:	3 Suicide 6 Could 4 Homicide determ		y - At home, farm, stre (Specify)	et, factory, office		28f. Location (St. City or Town	reet and Number or F	iural Route Number,	
۵	pital o		29a. Certifier 1 Certifying							- 1	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical E	Physician: To the best of m xaminer: On the basis of exa Nurse Practioner: To the b	amination and/or investi	igation, in my opinic	on, death occurred a	at the time, date an	d place, and due to the	e cause(s) and manner stated.	
	To the within To the comp	2	29b. Signature and title of certifier			20c License	number		Old Data singed (Man		
				memo	me	200	52948		SEPT 9	2010	
ر			30. Name and address of person v	vho completed cause of de	ath (Item 23a) (Type, P	rint) LENS AU	E 00-	C - M C	77 7	1228	
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	Stat Registra		31. Date fil <b>SEP</b> th, <b>P</b> 4 201	A See Hegistrar	's Signature						

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Marlena G. Grimes 2010 August 29 1:40 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 4, 1928 Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F Days Months Hours Mary Land 82 Yrs Director 212-36-2495 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 22a and any injury or other traumatin and any injury or other any or other traumatin and any or other traumatin and any or ot 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10799 Hickory Ridge Road #333 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Orlgln? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: black Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) laborer factory 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Maria SCruggs George Reece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6704 Chisholm Drive Baltimore, MD 21207 Janet Robinson/daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 
☐ Other (Specify) 21. Signature of Funcial Service V censee Ronald Wade, 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COMPUTE disease or condition resulting in death) 02270 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the artending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No g Unknown g Unknown been signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed Yes 2 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 No Other မ FUICO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider work?
1 Yes 2 No iniury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19 hate of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:38P M Thelma Rice Guthrie 9 2010 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24525 Hanson Road Laytonsville Montgomery Social Security Number ear If Under 24 Hrs. . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 💢 Months Aug 20 <sup>Y</sup>e 1932 Maryland Director 78 578-40-0101 Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland 1 Yes 2 X No Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20903 9736 Hedin Drive United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced White Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Admitting Officer</u> <u> Hospital</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Hitem 27 is marked of other traumatic even ပ္ Joseph Calvin Annie Beatrice Shaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Silver Spring, Maryland James B. Guthrie/husband 9736 Hedin Drive Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/14/2010 Woodbine, Maryland Going Home Cremation Service P.O. Box 784 Beverly 1. Heckrotte, P.A. Clarksville, M 21. Signature of Funeral Service Licenses uanita R M00957 MD 23a. Par 11 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Lung Cancer months Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Exami cate has t een signed by the attending physician and page 2 s rould be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No this certificate Yes 2 😾 No 1 Yes **Division of Vital** completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Daughter' Hospital 2 🕱 No Other: 1 🗌 Yeş မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Special 27. Manner of Death 28a. Date of injury (Month, Day, Year) is after death. 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 1 X Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital of 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D006699C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Vinni Juneja, M.D.

6420 Rockledge Drive, Suite 4100 Bethesda, Maryland 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#25 perME, G907, 972872010, WS State of Maryland / Department of Health and Mental Hygiene. 28697 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER Day REBECCA GOLDBERG 2010 9:27 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death STERLING HOSPITALITY BALTIMORE N/ASocial Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours 05/28/1913 Director Country) 97 216-36-9877 POLAND Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 5833 PARK HEIGHTS AVENUE, #202 21215 USA items ? death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 72 hours after 'natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. WHITE 3 XWidowed 4 Divorced Completed Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be Department of Health and Mental H
Important if frem 27 is marked oth
any injury or other traumative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ SAMUEL WISE PEARL RUBIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7901 WINTERSET AVENUE, BALTIMORE, MD AARON GOLDBERG/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANSHE EMUNAH AITZ CHAIM 09/12/2010 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician THRIVE FAILURE To disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXPANSIVE months SUBDUZAL HEM A TUMA Sequentially list conditions Examine d any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed tran and resulting in death) Last Due to (or as a consequence of) burialbeen signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? ☐ Yes 2 ☐ No this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident iniury 5 Pending UNKNOWN 1 ☐ Yes 2 No fall while walking MAMONAM Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5233 Park Meights Avinul Baltyman, MD 4 Homicide determined building, etc. (Specify) ASSISTED LINING Facility 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 030377 September 12, 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6503 PAPIL HEIGHTS ww PER M 30 BRACT VMD ZIZIT 31. Date filed (Month, Day, Year) 32. Registrar's Sanature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12 3. Time of Death Month Physician/ Margaret Mary Gerben 9:19 P. M September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium <u>Baltimore</u> 8. Date of Birth (Month, Day, Year) May 24, 1919 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F Country) 216-12-3686 Director 91 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director traumatic event, the Medical Examiner must be notified 28a-f 1 Yes 2 X No Maryland Baltimore Lutherville 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1306 McPherson Court 21093 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Yes 2 X No Black, White, etc. 1 Never Married 2 Married ð 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Proprietor Bar/Cafe Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Glick An<u>na</u> Bach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 1001 W. Joppa Rd. Baltimore, Sr. Mary Dolores Glick, Maryland 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 9-14-10 Baltimore, Signature of Funeral Service Licensee 22, Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc 6500 York Road Baltimore, Maryland 23a. Part 1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to in rediate cause. Enter Underlying Cause (Disease or linjury Examine Dise to for as a nonsequence of that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No Month Day Year 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d, Date signed (Month, Day, Year,

State Registrar JACKIE JONES,

31. Date filed (Month, Day, Year)

SEP 1 4 2010

DHMH 17 Rev 7/2009

p.m.

9:19

2010

GERBEN

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ss of gerson who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Ner (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 9,2010 5:06 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Greater Baltimore Medical Center Towson Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 😾 F Hours Country) 217-22-5818 95 **Director** 11-18-1914 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be a considered. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 3103 Leighton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: 3 XWidowed 4 ☐ Divorced Specify: African-American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Motor Vehicle State of Maryland 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph E. McIver Minnie Worthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3103 Leighton Avenue, Baltimore, MD 21215 Sylvia Hall/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation Temporal from State 4 Donation 5 Nother (Specify) 9-15-2010 Arbutus Memorial Park Arbutus, MD Signatur of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part I. Inter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death n signed by the a Id be detached fo g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day) Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

**Physician** /Medical **Examiner Funeral** 

show d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natu
any Injury or other traumatic event the statement

hours after death

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Baltimore,

**Physician** /Medical Examiner

The law requires that the death certificate be executed and burialattending physician for use as the burial use as the s been signed by the should be detached has h page 2

of Vital Records, P.O. Box 68760, this certificate or Attending Physician: director. funeral After within 24 hours after death

To the Funeral Director: completely filled in by the f Hospital To the 1 within 2 To the 1

Amend Item 5 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Year 8:55 PM **JEANNETTE** I. HUTSON 2010 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ROSE da / 2

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | 0 3 / 0 8 / 1 9 1 3 Square Franklin Hospital Baltimore 9. Birthplace (State or Foreign <sup>5</sup>**2<sup>S</sup>16<sup>A S</sup>28**7<sup>A</sup>**17B**9**0**7 **2 16 26 26 9 0** 7. Age (In yrs. last birthday 1□M 2🏞F 97 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County BALTIMORE 1 ☐ Yes 2 ☐ No Director MD ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 USA 8304 ALLISON LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: WHITE Specify: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STAMPING MACHINE MARTINS 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be COLEMAN IRENE HARRY SHAUCK ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY I. SPARACO/DAUGHTER 8304 ALLISON LANE BALTIMORE, MD 21237 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE CEMETERY 09/14/10 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityCVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Devere Se disease or condition resulting in death) Due to (or as a consequence of): olitis Sequentially list conditions, if any, leading to immediate cause. Errier or denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) tailure Due to (or as a consequence of): Physician/Medical E FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 9 00066995 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Akintid 9000 Franklin Square Drive Baltimore, md 21237 Adadoying filed (Month, Day, Year) State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** IIMORE If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) 8. Date of Birth Social Security Number **Funeral** Days (Month, Day, Months Hours Min M 2□F Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norther once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 □ No MOP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb r or Rural Route Number, City or Town, State, Zip Code) LTIMORE, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Daté cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility THE Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complication. hat caused shock, or heart failure. List only one cause on each line. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Yes signed by the a d be detached for Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Records, Completed pluods 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perform death? 2 🗌 No After this certificate 1 Tes Yes 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending iniury Natural N 2 🗌 No within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifle 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Physician/ Month Charles Hunter Morton 2010 Medical :47p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NA 5505 Fernpark Ave Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 1 M 2 D Months Min Yrs Director 191 MD 218-07-7319 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits aţ Director notified 1X Yes 2 □ No Baltimore MD NA 2010 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Siloueu or more and Montal Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be 1 Funeral 21207 5505 Fernpark 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify. 3 Divorced 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pepsi Cola Company 12th grade 4yrs Laborer Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles E. Hunter Virginia Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fernpark Ave, Baltimore, Md 21207 Carolyn Johnson-Sister 5505 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Vet 9/15/2010 Owings Mills, rrison 21. Signature of Funeral Service License 22. Name and Address of Facility
March F/H West Wabash Baltimore, 4300 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant ☐ Unknown Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy Hospital or Attending Physician: The certificate Yes 2 0 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one Be Hospital: Other: 1 🗌 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After 1 work? 1 ☐ Yes 2 ☐ No 5 Pending iniurv Natural in 24 hours area where the Funeral Director: Af Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Harris Physician/ 2010 1305 Medical 4a, Facility Name (if not institution, give street and number)
St. Maris County H 4b. City, Town, or Location of Death 4c. County of Death Examiner Nary's eonardtown If Under 1 Year If Under 24 Hrs Social Security Number Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F 29 2485 Months Days Carolina Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic area. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore Yes 2 ☐ No md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Poplar Grove St. 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2. If Yes, Give Year or Dates. 2. No Baltimore, Maryland 21215-0036 1 🗆 Yes 2 No Specify. Specify: Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) onstruction ioth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🗌 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donatiø 21. Signaturi Funeral Service Lice ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Hemorrage Pilysician Medical resulting in death) Due to (or as a consequence of): Examiner Esquer thany fist conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 L Yes 2 L 9 Unknown Yes 2 No. Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work? 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati ρ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL PATRICIA 15 many 31. Date filed (Month, Day, gistrar's Signature Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 28704

		1- For State Registrar	Certificate of	Death		Reg.	No.	
Physicia Medical Exami		1. Desedent's Name (First, Middle, Last) Rebecca Holley				Date of Death     Month     September 6	ay Year 5, 2010	3. Time of Death 1900 hrs
)		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Bayview Medical Center	4	b. City, Town, or I Baltimore	Location of Death		4c. County of Deat	h
Funeral Director		5. Social Security Number  6. Sex  7. Age (In Line of the second of the	yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days		<b>-</b>	1930 Society 1930 Poreign Co.	
land f show any once.	tor	10a. State 10b. County 10c.	City, Town or Location	10re				10d. Inside City Limits 1 Yes 2 No
h the Maryland 3a or 28a-f show otified at once.	Director	3 Mariners Walk Way		10f. Zip Code 2/2	20	10g.	Citizen of What Cou	ntry?
Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Reath and Mental Hygiene.  Itant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	No If Ye	es, specify Cuban,	panic Origin? (Sp , Mexican, Puerto specify:		14. Race - Amer White, etc. Specify:	ican Indian, Black, ACK
5-0036 ed within 72 hours afte tygiene. other than "natural",	Completed	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12)  College (1-4 or 5+)	during mo		on (Give kind of w DO NOT use retir		Sb. Kind of Business/ Arama	
MD 21215-0036 2 should be filed within th and Mental Hygiene. 27 is marked other tha umatic event, the Medic	o Be	17. Father's Name (First, Middle, Last)  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type, Print)	i 19h Mailing		Rose 1	(First, Middle, Maid	den Surname) r, City or Town, State	- Zin Code)
and 2 shou fealth and I traumatic		Blake Holley Husbar	bd 3 Man 20b, Place of Dispositi	riners U	Nalk h	lay Ka.	HIMOVE, M	ld. 21250
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Significant of Funeral Secretary Licensee	crematory or other	ar place) Ark ame and Address	9// gf,Facility	4/10	RaHimone 15 york K	Maryland
ம் திதித்தி Physician	-	23a. Part I. Enter the disease, or complications that caused the difficulty. List only one cause on each line. Hypertens	leath. Do not enter the	Jahn ('. (	Such as cardiac or	respiratory arrest,	FIMOVE, MA shock, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequent)	ng hip tra	ctures	Lic card		r disease	Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ice oi j.					
ecuted and transit		events resulting in death) Last Due to (or as a consequend	ice of):					
760, ficate be executed 3 physician and the burial - transit		UNPENDED AMENDED 23a, PII, 27 IF FEMALE: 23c. If yes, outcome of	,28a-f,per	ME G909	9 11/18/		23d. Date of delivery	
, P.O. Box 687 rres that the death certific signed by the attending is detached for use as it is the content of the detached for use as it is the detached for use and the detached for use as it is the detached for use as it is the detached for use and the detached for use as it is the detached for use as it is the detached for use and the detached for use and the detached for use and the detached for use as it is the detached for use and the	cian/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown	of docath =	ol death 3	Ectopic pregnar	ncy	Month D	day Year
P.O. res that the signed by t	۵	Part II. Other significant conditions contributing to death but red Diabetes mellitus; chronic			ven in Part I.	_	co use contribute to	the cause of death? ably 4 Unknown
Division of Vital Records, P.O. Box 68 not the Hospital or Attending Physician: The law requires that the death certificate hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed	Obesity				24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of
ital sician:	æ	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2	ER/Outpatient	-	of Death (Check o		idence 6 Other	
n of V ding Phy L. After thi funeral d	9i: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Inju	ury 28c. Injury	at Work?	28d. Describe how	injury occurred Su	bject was
Division of ' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification	2 X Accident 3 Suicide Could not be    Pending   9/3/2010   9/3/2010   28e. Place of Injury - 1	4:28 pm At home, farm, street, adway			collisio	n	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	<u>न्</u>	29a. Certifier 1 Certifying Physician: To the best of my know one)  2 Medical Examiner: On the basis of examination and manner stated.	vledge, death occurre on and/or investigatio	d at the time, date n, in my opinion, o	e and place, and o	due to the cause(s)	and manner as state	d.
F % F 3	Ĭ	29b. Agrature and title of certifier		29c, License O.C.M			d. Date signed <i>(Mon</i> eptember 9, 201	
		30. Name and address of person who completed cause of death ( Laron Locke MD. Assistant Medical Examine	· · · · · · · · · · · · · · · · · · ·	Street, Baltime	ore, MD 2120	1		
Sta Registr		31. Date filed (Month Sep) (Year) 4 2010 32. Registrar's Sig		Kel				

OCME

Physician/ Medical Baltimore, Maryland 21215-0036

SEPTEMBER 10, 2010 6:46 p.m.

For State Registrar

Division of Vital Records, P.O. Box 68760

BARRY HAMILTON

Examine	r	4a. Facility Name (if not institution, give street and number)  Stella Maris Hospice		4b. City, Town, or Timoniu	r Location of Death <b>IM</b>	1	4c. County of Balt:	inore
Funeral Director		5. Social Security Number 216-52-7452  Usual Residence of Decedent  6. Sex 1 □ X M 2 □ F	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 21	Year) 1952	9. Birthplace (State or Foreign Country) Maryland
faryland 3a-f show lified at	- 1	10a. State 10b. County 10c. 0	City, Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
with the A		10e. Street and Number  3 Kennard Avenue	<u></u>	10f. Zip Code 2104	10	1	0g. Citizen of W	hat Country?
or or	≥	11. Marital Status  1  Never Married 2  Married   12. Was Decedent Ever in UArmed Forces?  1  Yes 2  No If Yes, Give		Vas Decedent of H. Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Black	- American Indian, , White, etc.	
72 hours an "natural	Completed	Widowed 4 Divorced Year or Dates.      15. Decedent's Education     (Specify only highest grade completed)	16a. Deced	ent's Usual Occup		king	Specify:	White siness Industry
led within Hygiene. other thai	ぬけ	Elementary/Seconday (0-12) College (1-4 or 5+) 9  17. Father's Name (First, Middle, Last)	ng					
Mental I Mental I Mental I Mental I Mental I Marked I Mar	₽	Calvin (nmn) Hamilton				ne (First, Middle, M larie Bon		
and 2 shouself and 2 is a second searth and searth and search and		19a. Informant's Name/Relationship (Type, Print) Paula Hamilton / Wife	3 Kei	nnard Ave		ral Route Number, ( rewood , M	D 21040	
t. Page 1 at training the training of training of the training of trai		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	inity L	natory or other place utheran (	Cem. 9-1	.4-10	Joppa, I	Dity or Town, State  Maryland
permit Depar Impor any in		21. Signature of Funeral Pervice Lights & Carlotte Lights & Carlot	22 I	Name and Address MCCOMAS I 1317 COKE	s of Facility Funeral H esbury Ro	lome, P.A ad, Abin	qdon, M	21009
Physician/ Medical		23a. Part 1. Enter the disease, or complication of hat caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  RENAL CANC	ath. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Examiner		Due to (or as a conse	quence of):					
cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last  b. Due to (or as a conse						и
cate be physicia the bur	ealca	d						
nat the death certificate be executed of by the attending physician and detached for use as the burial-transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 🗀	Ectopic pregnand Other (specify)	sy .		23d. Date Mont	of delivery th Day Year
	₽.	Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	/	oute to the cause of death?
5 0001	Completed					24a. Was an autopsy perform	pr ned? de	ere autopsy findings available for to completion of cause of eath?  ☐ Yes 2 ☐ No
Physician: The la this certificate ha ral director, page 2	o Re	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1  Inpatient 2	☐ ER/Outpatien	Othe	ace of Death (Checer: 4  Nursing H		nce 6 🗶 Other	(Specify) HOSPICE
eath.  or: After the funera	Certificate:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28b. Time of injury	28c. Injury work M 1 □		28d. Describe how	v injury occurred	ı
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral		4 Homicide determined 28e. Place of Injury - At building, etc. (Spec.	ify)			City or Town,	State)	or Rural Route Number,
the Hosp thin 24 hou the Fune mpleted fi	Med	29a. Certifier (Check only one)  3	ion and/or investi	gation, in my opinic eath occurred at the	on, death occurred a e time, date and pla	at the time, date and ce, and due to the c	place, and due t ause(s) and man	to the cause(s) and manner stated ner as stated.
		29b. Signature and title of certifier		29c. License	1979Z	29	Id. Date signed (	(Month, Day, Year)
104,		30. Name and address of berson who completed cause of death (Ite JACKIE JONES, CRNP 2300 DUL	, , , , .		TIMONIU	M, MD 210	093	
State Registrar		31. Date filed (Month, Day, Year) 32. Figistrar's Sign SEP 1 4 2010	ature .	aki				

Fu

Dire

	for State Registrar		Otato	or warylar		tificate o				Reg. No.			
n	1. Decedent's Name AShira	(First, Middle,	Last)		H	ìrsh		Š	Date of Dea	Day	, 2010	3. Time of 3:42	Death A
il T	4a. Facility Name (If	not institution,	give street and no	umber)		4b. City, Towr	, or Location	of Death	Apranta	4c. Co	ounty of Death	- 1	
	The Johns I	Hopkins	Hospital	,		Baltimo			•		N/A		
	5. Social Security Nu 111-40-0		i. Sex 1 □ M 2X F	7. Age (In yrs. 60	last birthday) Yrs.	If Under 1 Ye Months Da		Min.	B. Date of Birt (Month, Day 08/01/.	, Year)		nplace (State o	Forei
	Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside Ci	
Director	MD	N/	A		BALTIM	ORE						1 XYes	2 _ 1
Oire	10e. Street and Num	ber				10f. Zip-Cod					n of What Cou	untry?	
<u>ā</u>	7017 PA	RK HEIG		NUE, #A2			21215				USA	I	
Funeral	<ul><li>11. Marital Status</li><li>1 □ Never Marrig</li></ul>	ed 2 Marrie	Armed	2 <b>X</b> No		Was Decedent If Yes, specify C 1 □ Yes 2√ I			ify Yes or No- can, etc.)		. Race - Amer Black, White pecify:	, etc.	
ed by	3 Widowed	4 X Divorced  15. Decedent's	Year or	Dates:	16a. Dece	dent's Usual Oc	cupation				of Business/l	WHITE Industry	
Completed	(Speci			(1-4 or 5+)	(Give kind of work done during most of working life. DO NOT use retired)						T.O.1.T		
Š	17 Fether's Name (	Eint Middle Le	5		NUR	SE	18 Mot	ther's Name	(First, Middle,		ICAL		
Re	17. Father's Name (F	-irst, Middie, La	ist)	FREU	IND			NINA	(Filst, Middle,	Walden S		IZME	
၉	19a. Informant's Na	me/Relationshi	p (Type. Print)	TKEC		ng Address (Sti			Route Numb	er, City or 1			
	JOSHUA H	IRSH/SO	N		283	5 MARNA	T ROAI	, APT	. в, в	ALTIM	ORE, M	D 2120	9
	20a. Method of Disp		B ☐ Removal from	20b.	Place of Dispo	osition (Name o	olace)	Da	ite	20c. Loca	tion - City or	Town, State	
	4 Donation			HAR	R SINAI ERETH	ISRAEL	CEM.	09/12	/2010	BA	LTIMOR	E, MD	
	21. Signature of Fun	eral Service O	ense		.	2. Name and Ad		. 50				S., INC	
_	23a. Art Efter th	nous	Du	t caused the deat		900 REI					ILLE, I	MD 212 Approximat	
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decade or Any) that initiated events resulting in death) Last  b.   CUKCMIQ   Due to (or as a consequence of):  c.   Due to (or as a consequence of):												
Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ☑ 9 □ Unknown	nonths?	1 Liv	outcome of pregne birth 2 Fet egnant at time of a	al death 3	☐ Ectopic pregr ☐ Other (specify				23	d. Date of del Month	*	Year
ρ	Part II. Other signifi	cant condition	s contributing to	death but not re	esulting in the	underlying caus	e given in Pa	art I.	23e. Did t			o the cause of obably 4 🗆	death? Unkno
Completed									24a. Was autor perfo		24b. Were au prior to death?	topsy findings completion of	availal cause
ပိ	25. Was case referre	ed to medical					26. Pla	ce of Death (	Check only o				
To B	examiner? 1 \sum Yes 2 \sum	No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DOA	Other: 4 🗆 I	Nursing Hom	e 5 🗆 Resid	dence 6	Other (Spec	cify)	
	27. Manner of Death	5 Pending	(Mc	e of Injury onth, Day Year)	28b. Time o Injury	] '	njury at Work? I □ Yes 2 [		8d. Describe	now injury	occurred		
Certification:	2 Accident 3 Suicide 4 Homicide	6 Could no determin	ot be 28e. Pla	ce of injury - At h Iding, etc. <i>(Speci</i>					8f. Location ( City or Tou		Number or Re	ural Route Nun	nber,
Medical C			xaminer: On the	ne best of my kno basis of examination									(s)
Me	29b. Signature and	title of certifier	/				ense numbe			29d. Date	signed (Month	h, Day, Year)	
) mo							ES-O	00		Sept	kinlær	10,2	210
	30. Name and addre		ho combeted c	ause of death (Ite	em 23a) (Type	, Print)		600 N	orth Wo	olfe St.	Baltimo	ore, MD,	212
	OF D	74.75		20	-	*							

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 11 2010 4:10 PM HECKER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NORTH OAKS HEALTH CENTER BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 11/3071912 Months Days Hours Country) Director 97 WV 219-26-4576 Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral 23a 725 MT. WILSON LANE 21208 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) REAL ESTATE AGENT REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ou ပ AARON TOTZ DORA **OFSA** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3635 ORDWAY STREET N.W., WASHINGTON, DC DANIEL HECKER/STEP-SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of Important: If it any injury or o once. 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM: 9/13/2010 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) weeks Medical Due to (or as a consequence Examiner it ico Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months? Day Pregnant at time of death Month the JI. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 4 Unknown 2 No 3 Probably 1 Yes peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Matural work? 5 Pending 2 🗆 No Accident Investigation 3 🔲 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Dire Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000

32. Registrar's Signature

Greenspan

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 5,01A M <sup>Year</sup> 2010 Diana Lynn Ittner 11 September Medical 4c. County of Death acility Name (if not institution, give street and number 4b. City. Town, or Location of Death Examiner lisbu WICOMICO If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** (Month, Day, Year 1 □ M 2 👽 F Months Hours Min. Country) Marvland 212-46-3380 64 1945 Director Oct Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Directo DE 1 🗌 Yes 2 🛛 No Sussex Selbyville 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 37063 Blue Bill Drive 19975 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ō þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White "natural", Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Head Cashier Liquor Distributor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important; If item 27 is many injury or other. 2 Perry Geoghegan Edna Thornton 19a. Informant's Name/Relationship (Type, *Print*) **Vernon** Mr. <del>Veron</del> Ittner / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37063 Blue Bill Drive Selbyville, DE 19975 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sept 15 2010 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Bla Onset and Death Immediate Cause (Final Physician/ usa brinary disease or condition resulting in death) Medical Due to (or as a cor sequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) -transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical I or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 Terobably 4 Unknown **Director:** After this certificate has been sid in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotential 2 Inpotential 2 Inpatient 3 Inpotential 2 Inpatient 3 Inpotential 2 Inpatient 3 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29505 09-11-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M. D., 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIO M. BELLOSO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#7, 8 per FH G907 9/14/2010 WS
State of Maryland Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Joyner 10:50 P.M William septem ber 2010 Medical 4b. City, Town, or Location of Death ital Center listown 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Hospice @Northwest Hospital Baltimore Seasons Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birt Dec . 10, 1912 Birthplace (State or Foreign **Funeral** 1**★** M 2 🗆 F Months (Month, Da Hours 237-38-0825 Director Carolina Usual Residence of Decedent 28a-f shov 10a. State with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/AMaryland X□ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 1203 Springfield Avenue permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2x No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2√☐ No Specify. Completed 3 X Widowed 4 Divorced Specify: Black Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Barber <u>Unknown</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Hardy Ardro Joyner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239203 Springfield Ave Baltimore, Maryland Esther Black/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place, Woodlawn, Maryland Memorial Park9/13/10 4 ☐ Donation 5 ☐ Other (Specify) King 22. Name and Address of Facility Chatman-Harris Funeral Home . Signature ... Funeral Barrice I 5240 Reisterstown Rd Baltimore, MD 21215 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line Onset and Death End-Stage Ph sician/ Cardiomu disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Dav Year Pregnant at time of death been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗂 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Woth 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 D Natural 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOUS 7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-203, Baltimore, MD. 21209-· Kayapakse Mo 31. Date filed (Month, Day, Year) 32. Registrar Signat State SEP 1 4 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 1 0 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day September 1 **Physician** 2010 5:25 a.M Sarah W. Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Baltimore **Emerald Estates** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 T Hours 165-14-2291 MD 88 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow Examiner must be notified at 1 ¥ Yes 2 □ No Funeral Director n/a Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3855 Greenspring Avenue iteme 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 5 1 ☐ Yes 2√2 No Specify: þ Specify: African-American ₩ Widowed 4 Divorced "natural", al Hygiene. d other than "natura event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygies Important: If Item 27 is marked other to any injury or other traumatic event, III. 2008. SSA Claims Adjuster 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lela Stanley ပ Charles Herdon Wongus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Woodbrook Lane, Philadelphia, PA 19119 Ronald Jones/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland national Cemetery Laurel, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. Signatury of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stood, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SVITZBOND Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, It ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-trar Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No.
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 1 Yes 2 0 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 sidence 6 Other (Si ۵ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Dea 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

Certification: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title offcertified 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

(0/16 M Me 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEIGHT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Rag. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month Physician SINOL ZŰ /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gardens AKeville If Under 1 Year | If Under 24 Hrs. Funeral 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 84 Yrs. Months Days Hours Min 1 □ M 2 XF Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits MO other traumetic event, the Mcdical Examiner must be notified Kandallston 1 Yes 2 XNo **Funeral Director** Baltimone 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 USA Kond 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 XNo Specify: Black Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Department of Health and Mental Hygiene Importent: If item 27 Is marked other than any injury or other traumetic event. Ite M. 2006. College (1-4or 5+) Elementary/Secondary (0-12) Furniture 12th grade Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Abram Kittvell ု Bumer Dora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3927 Tiverton Road Randallsown MD 21133 bert L. Jone 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arbettus Memorial Pork Faltinone, MD 109/20/2010 \* 4 ☐ Donation 5 ☐ Other (Specify) Vaughn C Greave Fun eval services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Road Pandallotown MO2133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 6 Mach disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): Sequer tially flet so rail(ore, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed pertension Due to or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 menths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? 2 E No 3 Probably 4 □Unknown 1 Tes Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? 26. Plage of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No Certification; To 1 🗀 Yes Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the desire of examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Jones

32. Registrar's

10-06388 John Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 28712

		1- For State Certificate of Death Reg. No.
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year August 24, 2010 3. Time of Death 1046 hrs
		4a. Facility Name (if not institution, give street and number)  Union Memorial Hospital  4b. City, Town, or Location of Death  Baltimore  4c. County of Death
Funeral Director		5. Social Security Number Ink 6. Sex 17. Age (In yrs. last birthday) 1 X M 2 F 69 Yrs. 18 Months Days Hours Min. 18 Days Hours Min. 1941 Foreign Country)  The last birthday of the foreign Country Co
Maryland 28a-f show any d at once.	l in	Usual Residence of Decedent  10a. State
with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number         10f. Zip Code         10g. Citizen of What Country?           123 W. 29th Street #15A         21218         USA
ter death wii ", or items ? er must be r	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Yes 2 No unk  16. Yes, specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  17. Yes 2 No specify:  18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  19. Specify:  10. Specify:  10. Specify:  11. Acole
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed by	3   Widowed   4   Divorced of Pres, Give Year of Dates:   1   Yes   2   Mo   specify:   Specify:   black
21215-0036 21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Com	17. Father's Name (First, Middle, Last)  unk  18. Mother's Name (First, Middle, Maiden Surname)  unk
MD 21 nd 2 should 1 ulth and Mer m 27 is mar	To	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  0.C.M.E. 111 Penn Street Baltimore, MD 21201
Baltimore, permit. Pages I ar Department of Hee Important: If ite		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
		21 Signature of Funeral School Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause or each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death  Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause
ecuted and - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
760, icate be executed physician and the burial - transi	Medical	UNPENDED AMENDED  IF FEMALE: 23d. If yes, outcome of pregnancy 23d. Date of delivery
Box 687( e death certifica the attending pled for use as the	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (Specify)  9 Unknown
s, P.O. E ires that the c signed by the	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vunknown
Division of Vital Records, P.O. Box 68. the Hospital or Attending Physician: The law requires that the death certifing A hours after death. the Funeral Director: After this certificate has been signed by the attending rupletely filled in by the funeral director, page 2 should be detached for use as the state of the	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
fital Residents: The is certificate lirector, page	Be	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Warsing Home 5 Residence 6 Other:
ion of V tending Phy eath. or: After th	ation: To	27. Manner of Death  1 Valural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No
Division  Hospital or Attendin 24 hours after death. Funeral Director: A	Certification:	Suicide 6 Could not be determined Could not be Homicide Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Di To the Hospital within 24 hours a To the Funeral I	Medical (	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  August 25, 2010
	ŀ	30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regis	ate trar	31. Date filed (Month, Day, Year) SEP 1 4 2010  32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0850 **Physician** 10 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A FUTURECARE HOMEWOOD NURSING CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 耳F NEW JERSEY Director 7-20-1920 220-05-5248 nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ardment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show hilly or other traumatic event, the Medical Examiner must be notified at Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No BALTIMORE Director N/A MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 **USA** 100 ZEPPELIN AVE. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: BLACK 3 → Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT STATE OF MARYLAND -12-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ CHARLES TERRY GERTRUDE TENDER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHEILA MOBLEY (GRANDDAUGHTER) 124 MILTON AVE. FALLSTON, MARYLAND 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) LOUDON PARK CEMETERY: 9-15-2010 BALTIMORE, MARYLAND JONATHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 21. Signatur 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedite Cause (Fi disease or condition result if g in death) te Cause (Final **Physician** /Medical ge to (or as a onse quence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Mroknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Certification: 5 Pending investigation 1 Naturai 1 Tes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only and manner stated 29c. License number

State Registrar 29b. Signat

Year)



death (Item 23a) (Type, Print)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Johnson 11:15 AM September Xiomara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7927 Lansdale Road Dundalk Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** .1<u>960</u> 1 🗆 M 2 💢 F Months Days Hours Yrs Director 613-26-8796 50 Panama Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Dundalk Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7927 Lansdale Road 21224 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 No Specify: Specify: Hispanic "natural" Completed 3 Divorced Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Hospital 12 years 4 Years Director of Pathology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfonso Bowen Jacinta Parkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 i any injury or other tra Caroline Johnson Daughter 7927 Lansdale Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 9. 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, complications that caused the death. onot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes No Month Pregnant at time of death Day Year detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? certificate 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🖸 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗗 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 Yes Accident Investigation Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours to the Fune completed fi 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) em 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Ten Ave RALTIMUM AND 2124

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, AMEND ITEM#1perpHYS#10e,17,19b, perFH, G907,9 / 16 / 2010, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. N. 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Linda Kenahan Physician/  $^{^{Day}}\!2$ 2010 6:45pMedical September 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 103 Trappe Road Baltimore Dundalk . Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth **Funeral** 1 M 2 F Months Days Hours Min Dec. 16 Director 144-46-1900 56 Usual Residence of Decedent 10a. State 10b. County with the Maryland at 10c. City. Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh الله عند 23a or 28a-f sh الله عند 23a or 28a-f sh 1 🙀 Yes 2 🗆 No N/AMaryland Baltimore 10e. Street and Number 4214 Bayonne Avenue 4214 Bayonna Avenu 10f, Zip Code 10g. Citizen of What Country? by Funeral United States ural", or items 2 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) ed other than event, the N d Mental Hygiene. marked other tha Computer Programmer Self Employed Be 17. Father's Name (First, Middle, Last) Kenahan Andrew Kenaham 18. Mother's Name (First, Middle, Maiden Surname) မ f Health and Ments item 27 is marked other traumatic e Jean Simmonette 19a. Informant's Name/Relationship (Type, Print) 185 Mailing Address (Street and Number of Bural Boute Number, City or Journ State 21206 103 Trappe Road, Dundalk, Maryland 21222 Andrea N. Grzechowiak, Daughter other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 9/13/2010 Metro Crematory, Inc. Baltimore, Maryland Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) ERVICAL Month Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or imjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year signed by the a 1 Yes 2 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law has page 2 s autopsy performed? death? After this certificate 2 No 1 Yes 1 ☐ Yes 2 👿 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? <u>Daughters</u> Hospital 1 Yes 2 XNo Other: ည 4 🗆 Nursing Home 5 🗆 Residence 6 🖾 Other (Specify Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 24 hours after deatl 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature)and title of certific 29d. Date signed (Month, Day, Year) 200 13 46988 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIMA COUZI 7501 21204 OSLER MD 10WSON 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State arko Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Betty Lois 08:10 PM Kro11 Medical 2011 nitember 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 408 5. Social Security () 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Nov 7,1926 6. Sex **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign 1 ☐ M 2 🛣 F Months Days Hours Director Mary Tand 83 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fine 77 is marked other than "nature," any injury or other trainment. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD. Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 307 4TH Ave. 21227 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th N/A Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lacey Light Molly Connelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Kroll, Jr./ Son 2B Glenwood Rd., Essex, Maryland 21227 Eugene 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery Sept.13,2010 Glen Burnie,MD. 4 ☐ Donation 5 ☐ Other (Specify) Signatur Funeral Service Licensee AMBRUSE AFUNERALLY HOME OF LANSDOWNE 19tun Hammonds Ferry Rd., Lansdowne, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nse and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conse dence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Recodds, P.O. Box 68760 Physician/Medical attending pl for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown as been signed by the atter Month Day Year Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Tes Bchizophsenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA □ Nursing Home 5 □ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
7 Per FH G907 9/14/10 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER Pay 12, 2010 8:45 P M Physician/ KULEFSKY SARAH Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE BALTIMORE 401 YESHIVA LANE, #2A 9. Birthplace (State or Foreign Country) AUSTRIA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 11/24/11/921 Days Hours 1 M 2 X F Yrs 88 216-25-7756 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland at Hygiene. do wher than "natural", or items 23a or 28a-f shoo went, the Medical Examiner must be notified at Director 1 Yes 2 No BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21208 401 YESHIVA LANE, #2A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 2 WHITE 1 ☐ Yes 2x No Specify: Specify: 3 🔽 Widowed 4 🗆 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 7. Father's Name (First, Middle, Last)
Eliezer
ELIZER should be file and Mental F is marked o UNKNOWN မ **ESTHER GARTENHAUS** permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 429 YESHIVA LANE, BALTIMORE, MD ETTIE ROSENBAUM/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ■ Burial 2 □ Cremation 3 □ Removal from State 09/13/2010 BALTIMORE, MD AGUDATH ISRAEL CEM. 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consumence of) 3 don Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine CEREBRO VASCULAV To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Medical Certificate: To Be Completed by Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 -No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy page 2 s 1 Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, examiner? Hospital Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of De 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending s after death.

I Director: After in by the furnishment. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours after

To the Funeral Directory

completed filled in b Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Proofficer: To the best of my knowledge, death occurred at the time date and place and due to the cause(s) and manner as stated. 29a. Certifiei only one 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifie 29c. License number 025039 ss of person who completed cause of death (Item 23a) (Type, Print) Smith Aue, Suite 207, MB 21209 2835 MD 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9, 9:05 P M Lorch Cletus J. September 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1220 A Hillcreek Road Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days 1 1 M 2 □ F 91 Yrs 488-18-2069 March 19,1919 Director Missouri Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marith and Mental Hygiene.
?? is marked other than "natural", or items 23a or 28a-f sh traumatic event, it e III all Exp. (inst. must be notified. Director 1 ∏Yes 2 X No Maryland Anne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1220 A Hillcreek Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐XYes 2 ∐ I If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1939-45 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph В. Lorch ပ Anna Geisler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Hilda M. Lorch - wife 1220 A Hillcreek Rd., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Haven Cemtery Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Sept.13,2010 22. Name and Address of Facility 21. Signatury of Funeral Service Livensee Stallings Funeral Home, PA Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician arcinomo 9 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Examir and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) <u>Р</u> О the ò signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate ha mpletely filled in by the funeral director, page 1 ☐ Yes 2 No Division of Vital 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Mertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 325 Hormtal Uny Egc. License number 29d. Date signed (Month, Day, Year) sician Burniemo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325

State Registrar Gunmee T 31. Date filed (Month, Day, Year)

1 4 2010

DHMH 17 Rev 1/2001

SAWHNEY MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01iver September 2010 Joseph Litzinger, Jr 6:33 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson 6. Sex 1 A M 2 A F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 21 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min Director 218-68-6906 Mary land 54 Sept Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f chomany injury or other traumatine event. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 112 Glenmoore Avenue 21030 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph 0. Litzinger Ruth 0cker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kathleen L. Litzinger/Wife</u> 112 Glenmoore Avenue, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donatjon 5 Other (Specify) Atlantic Crematory 9/11/10 Glen Burnie, Maryland 22. Name and Address of Facility Bryan W. Clar emmon Funeral Home O W. Padonia Road, Home of Dulaney Valley Inc. Road, Timonium, Maryland 21093 23a. Part 1. Er er the disease, or complication shock, or heart ailure. List only one cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each Immediate ( ause (F)hal Physician/ Onset and Death Frefatic me Hapatocellviar Carcun disease or andition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 🙀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ XNo Other: 4 Nursing Home 5 Residence 6 Cother (Specify) va-tog <u>유</u> 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 1 Tes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 1 Cary R125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 015 Month 0 PMI 7:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** zabeth Lente altimore 6. Sex 7. Age (Ir yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

June 13, 1918 **Funeral** 9. Birthplace (State or Foreign Days 1 □ M 2 🔀 F Months Hours Min West Virginia Director 234-07-5631 92 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 21/2 No MD Howard Elkridge 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6343 Euclid Avenue 21075 USA items ? 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 □ Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Charles Keffer Grace Nolf permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Lloyd-Son 6343 Euclid Avenue, Elkridge MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Crestlawn Mem Garden Sept 8,2010 Marriottsville 4 ☐ Donation 5 ☐ Other (Specify) Euneral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home Inc. Sulphur Spring Road Arbutus MD 21090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ehysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail 302.
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year sate has been signed by the page 2 should be detached 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by oidism 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes nideini Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performe death? 1 ☐ Yes 2 ☐ No **Director:** After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 욘 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina 1 Yes Investigation 2 🗌 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifle 30. Name and address of person who completes ase of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 2872 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pater Levine SEPTEMBER D 2010 6:55 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 27 CHERRY MANOR COURT BALTIMORE REISTERSTOWN Social Security Number 6. Sex 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Months Days Hours 0676271959 51 **Director** 019-38-1717 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10g. Citizen of What Country? Funeral 27 CHERRY MANOR COURT 21136 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE "natural" Specify Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 Popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Madric once. 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) CHIROPRACTOR MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MARK LEVINE MARSHA SUCOFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK LEVINE/FATHER 7720 GRASTY ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE MEM.PK. 09/12/2010 ELKRIDGE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician corones arrived disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 37 00 13 dubctes mellity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performe death? Yes 2 No 1 🗌 Yes 2 🗆 No neral Director: Atter this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) when c Bay , +D 9/8/10 D0020604

MDHMH 17 Rev 7/2009

State Registrar Richard A. Sers, mo; sure 450; 10755 Folls Read, Luthernille, Hd 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month September Ola Manlev 2010 7:55 p. м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4445 Linthicum Road Dayton Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2X F Days Months Hours Min 227-50-2257 Director 68 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mentals. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD 1 ☐ Yes 2 🙀 No Howard Dayton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4445 Linthicum Road 21036 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married 2 X No Completed by ☐ Yes 1 Yes 2 No Specify. If Yes, Give Year or Dates African-American 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 RN  $G\!P\!M\!C$ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shirley Crews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Manley/ Husband <u>4445 Linthicum Road, Dayton, MD 21036</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) King Memorial Park 9-13-2010 Woodlawn, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Wile Functal Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. There the disease, or complications that cause should or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a consequence of a attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Dav Year 2 No been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should b 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate I 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 💇 Natural 5 Pending work? 1 ☐ Yes Accident
Suicide Investigation 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Director: / within 24 hours aft

To the Funeral Di

completed filled in Medica 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number D185 and address of who completed cause of death (Item 23a) (Type, Print) an 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 142010 Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FODEN Month 105 5.45 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Manon Baltimore Catonsville 5. Social Security Number 7. Age (In yrs. last birthday, If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 - M 2 F Hours (Month, Day, You Year) Country **Director** 212-42-2778 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location ould be filed within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or items 23a or 28a-f sho 10a. State 10d. Inside City Limits Director 1 X Yes 2 No Baltimore NA MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21227 3310 Benson Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black. White, etc Completed by 1 Never Married 2 Married 1 Yes : 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Long Green 12th grade College (1-4 or 5+) 2 yrs Nursing Home Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Cora Madden <u>Andrew Madden</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harford Ct, Baltimore, Md <u> Elizabeth Jackson-Daughter</u> 826 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Memoral Park 9/11/2010 Woodlawn, Md 21. Signature of Lareral Service Licensee 22. Name and Address of Facility

March F/H West 300 Wabash Baltimore, 21215 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or a a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performe Yes 2 1 Tes 25. Was case referred to medical examiner?

1 Yes No Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? \_1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 within 2 To the F only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

LIADAT ALI. 821 N - EulaW St. Baltimore

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#6perFH, G907, 9/15/2010, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Betty E. Mitchell Year AM 2010 Medical ntember 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/AHimore Hosnita . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-22-3996 1 ☐ M 2 🗷 F 83 Months Days Hours Min S(Mpth, Day2Year) 1927 Country) MD Director Usual Residence of Decedent or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Morrell Park 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2524 Washington Blvd. 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Russell Geiman Cora Alice Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).ter 2524 Washington Blvd. Baltimore, MD. 21230 Sharon Elaine Stevenson, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Park Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 9-11-2010 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician COPI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Premova Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending the control of the second of the ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Mitchell, Betty E Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 month 1 Yes 2 No Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 ₹ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to riedical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospita 2 No 1 Tes Other: ER/Outpatient 3 DOA Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, detail occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) MD 09/07/2010 P2349 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Miriam Marie September Mayo 2010  $\mathbf{P}^{\mathsf{M}}$ 10:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Chevy Chase Chevy Chase Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days Hours 317-36-7104 72 February 4, Director Indiana 1938 Usual Residence of Decedent fshow 10a. State 10b. County death with the Maryland 10c, City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 28a-f Maryland Montgomery 1 Tes 2 X No Chevy Chase 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 8700 Jones Mill Road 20815 United States items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No , O. Black, White, etc. 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after of meeth and Mental Hygiene. Insert of Heath and Mental Hygiene and watt if item 27 is marked other than "natural", or litry or other traumatic event, the Medical Examiliury or other traumatic event, the Medical Examil. ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Flight Attendant Airline Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ಲ James J. Mayo Not Available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dina Zupnik / Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other ti 13815 Drake Drive, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State September 11, Montgomery Crematorium, Inc 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 . Signature of Funeral Service Licensee M01596 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Acute Myocardial Infarction Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atherosclerotic Vascular Disease Years Sequentially list conditions, harry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Hypertension Years Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Late Effects Cerebral Vascular Accidents, Dysphagia Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No eral Director: After this certificate | filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature d title of cert 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Signati

Susan Miller, MD

4 2010

353

8218 Wisconsin Avenue, #305, Bethesda, Maryland 20814

2010

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	1arylan		artment of H		and Me	ental Hyg	giene			
			Registrar			Cei	tificate of L	Death			Reg. No.	2010	22726	
	Physicia		Decedent's Name (First, Middle,     Man	Last)	Bail	lev M	cCaleb			2. Date of Dea Month eptemb		8, 20 <sup>°</sup> 1°	3. Time of Death 10:25 A M	
	Medic Examir		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or	r Location of				4c. County of Death		
			Montgomery Hosp	ice Casey F	louse		,,,,,,	Rocky				Montgome	ry	
	Funeral		5. Social Security Number 232-32-0418	6. Sex 7. Ag		ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		B. Date of Birth (Month, Day ugust 15	Year)	9. Birth	olace (State or Foreign	
	Director		Usual Residence of Decedent		83	115.			[ A	ugust 15	, 19	2/ West	Virginia	
	and show	ŏ	10a. State 10b. County		10c. City	y, Town or Lo	cation	-				1	I0d. Inside City Limits	
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	h the	Funeral Director	10e. Street and Number				10f. Zip Code				_	izen of What Cour	•	
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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		11. Marital Status  1  Never Married 2  Marri	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give	?		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🙀 No			y res or No- can, etc.)		14. Race - Americ Black, White,	etc.	
21215-0036	ours a atural	Completed by	3 Midowed 4 ☐ Divorced  15. Decedent	Year or Dates.									ite	
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	filed tal Hy d oth event	o Be	17. Father's Name (First, Middle, La	•				18. Moth	er's Name (F	irst, Middle, N	Maiden S	Surname)		
yla	Ind be Ment narke natic	잍		Bailey		1		Na	aomi	Decker	:			
Maryland	2 shouth and the and the traum		19a. Informant's Name/Relationshi Michael McCale	p (Type, Print) b / Son			ng Address (Street a berry Hil						Code) 1and 20877	
	f Heal item other		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of		Dat	e		ocation - City or To		
m m	Page nent o ant: If iry or		1 🖾 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Park	emetery, cren Lawn Me	natory or other place morial Par	k j	Septen 11, 20	nber	Rock	ville, N	Maryland	
Baltimore,	permit. Departi Import any inj		21. Signature of Funeral Service Li	maret	M0130	05 R	Name and Address Dert A. Pu	ss of Facilit	y Funera	al Home/	Rock	ville, Inc	20850–2805	
			23a. Fari 1. F ter the disease, or o shock, ir heart failure. List or	omplications that cause	ed the death								Approximate Interval Between	
	Physician/		Immediate Cause (Final disease or condition	Sepsis									Onset and Death	
4	Medical Examiner		resulting in death)	Due to (or as		ence of):								
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Division of Vital Records,	or Attending Physician: The law requires that the death certificate be executed after death. Differ death. Differ contificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ot be			eet, factory, office		28f	f. Location (St. City or Town		l Number or Rural	Route Number,	
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	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	(Check 2 \(\sumeq\) Medical Ex	Physician: To the best of aminer: On the basis of e Nurse Practioner: To the	examination	and/or invest	igation, in my opinio	n, death oc	curred at the	e time, date an	d place,	and due to the cau	use(s) and manner stated.	
	To the within 2 To the comple		29b. Signature and title of certifier				29c. License					e signed (Month, L		
			1 Coloner V	8		D3714	42			Sep	tember 8	, 2010		
5			30. Name and address of person w					Max-	,1 ond	20850				
	Stat		G. Coleman, MD 31. Date filed (Month, Day, Year)	32. Registra			ockviite,	mary	тапа	20030	'			
	Stat	.e	CED 1 4 2010	A SEL Hogisti	3								8.7	

DHMH 17 Rev 7/2009

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AMEND ITEM#23e, 26perPHYS, G907, 9/14/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year ewis HENry eptember 2010 3:05 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠** M 2□ F Months Days Hours Min. 69 217-38-2505 1941 June 12, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Carrol1 Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16306 Hanover Pike 21074 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Owens Virgie Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret H. Owens Wife 16306 Hanover Pike Hampstead, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 9/6/10 Hampstead, MD 22. Name and Address of Facility 21. Signature of Fundral Service Licenses 11824 Reisterstown Road ELINE FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Reisterstown, MD Approximate Interval Between Onset and Death Immediate Cause (Final Pulmona 91610 disease or condition resulting in death) Due to (or as a consequence o): LOSONAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1□ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation M 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria been signed by the should be detach funeral director, page 2 should hasl certificate this After 24 hours after death • Funeral Director: filled in by the

**Physician** 

/Medical

**Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

Be Completed by

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Physician/Medical

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Completed

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Certification: To

Medical

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nation".

within 24

Naveed SEP 1 4 2010 State Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Avenue Shah 32. Registrar's Signature 1. park

and manner stated.

29c. License number

Westminster, MD

64789

29d. Date signed (Month, Day, Year)

2010

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State	State of M	arylanc		artment of F tificate of L		nd Me			010	28728
			Registrar  1. Decedent's Name (First, Middle, L	ast)		- 001	incate or L	Jean		2. Date of Death	eg. No.		3. Time of Death
	ysicia		Adrian	S.			Pressle	W		Month 09	7 Day	20 <b>1</b> 0	12:05a.M
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	neral			Sex 7. Ag	e (In yrs. las		If Under 1 Year Months Days		4 Hrs. 8	B. Date of Birth (Month, Day,			nplace (State or Foreign
Dir	ector		216-90-6117 Usual Residence of Decedent	A	32	Yrs.			1	2 07	77		MD
pur	show at	ъ	10a. State 10b. County		10c. City,	Town or Loc	cation						10d. Inside City Limits
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the	or 2	اقا	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Cou	intry?
with	is 23s	Funeral	5903 Kayon Ave	9			212	206			τ	U.S.A	•
death	ner n		11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origir ın, Mexican, F	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		Race - Ameri Black, White,	
36 after	al", or xami	d by	1 ☐ Never Married 2x Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1	☐ Yes 2【 No	Specify:				ecify: Bla	•
21215-0036  within 72 hours after death with the Maryland giene.	cal E	Be Completed	15. Decedent's	Year or Dates. Education	-	16a. Deced	lent's Usual Occup	ation				of Business Ir	
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Maryland 21215-0036  2 should be filed within 72 hours after tith and Mental Hygiene.	r IS n		19a. Informant's Name/Relationship		1		g Address (Street a				-		
and Healt	rem 2/ is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	1	Monica Pressle 20a. Method of Disposition	ey-Wife	20h Pla		Kavon sition (Name of	Ave,	Bal Da			d 2120	
Page 1	yord		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Contro	Removal from State	cer	netery, crem	natory or other place					•	
Baltimore, permit. Page 1 and Department of Hea	Important: IT I any injury or c once,	-	21. Signature of Funeral Service Lice		King		orial P		<u> </u>	/201W	WOO	odlawı	a, Ma
De de de	E 8 8			arch		l M	arch F/	H Wes	st Ve.	Balti	imore	bM .e	21215
			23a. Part 1. Enter the disease, or co- shock, or heart failure. List only	inplications that caused	the death.								Approximate Interval Between
Physi			Immediate Cause (Final disease or condition	(01		un	cer					- 8	Onset and Death
	dical		resulting in death)	a. Due to or as									7000
LAU		<u>.</u>	Sequentially list conditions,	b. —									
pe	sit	Examiner	if any, leading to immediate	Due to (or as	a conseque	nce of):							
xecut	al-tran	Exa	that initiated events resulting in death) Last	C. Due to (or as	a conseque	nce of):							
; <b>68760</b> certificate be executed and inding physician and	should be detached for use as the burial-transit	edical		■ d.									
376 ificate	as the	Med	IS SERVALS.										
x 68/ n certific	esn .	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome			Ectopic pregnanc	:V			23d	. Date of deliv	very
<b>Box</b> death c	ed fo	sici	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)	-				Month	Day Year
cords, P.O. law requires that the las been signed by the	letach	F.	Part II. Other significant conditions	contributing to death b	ut not result	ting in the u	nderlying cause giv	en in Part I.		23e Did tob	acco use o	contribute to t	the cause of death?
S, P.	d be	d b	-				, 0			1 □ Ye	$\sim \lambda$		obably 4 🗆 Unknown
Vital Records, iysician: The law requires is certificate has been sid	should	Completed								24a. Was an	/		opsy findings available
<b>Rec</b> The law	ige 2	ğ							_	autopsy perform	y	prior to co death?	ompletion of cause of
an: Tr	or, pa		25. Was case referred to medical	1			26. Piz	ace of Death	(Check o	1 ☐ Yes 2	No No	1 🗌 Yes	2 ∐ No
VITS ysicia is cer	direct	10 B	examiner?	Hospital:	ent 2 🗆 El	R/Outpatien	t 3 🗆 DOA Othe			e 5 🗆 Resider	nce 6 X	Other (Specif	w har Due
of Pi	neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injui	ry 2 /, Year) 2	8b. Time of injury	28c. Injury work	at at		d. Describe hov	-		
lon tendii leath.	the fu	<u>i</u> iga	2 Accident Investigation 3 Suicide 6 Could not	on				Yes 2 N	0				
DIVISION OT tal or Attending Ptrs after death.	in by	Certificate:	4 Homicide determine			e, farm, stre	et, factory, office		28	f. Location (Stre City or Town,		ımber or Rura	al Route Number,
Spital ours	filled	edical	29a. Certifier Certifying Ph	ysician: To the best of	my knowlec	dne death o	ccured at the time	date and nia	ace and	tue to the caus	e(s) and m	anner as stat	ed
DIVISION Of VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific	completed filled in by the funeral director, page 2	Medi	(Check 2 Medical Exar		xamination a	and/or investi	gation, in my opinio	n, death occu	irred at th	e time, date and	place, and	d due to the ca	ause(s) and manner stated.
70 ¥ithir 15 ±	dwo o		29b. Signature and title of certifier	1/1000		g .	20c License	number		20	ad Data si	anad (Menth	Day Veerl
			· you		>		I D	505	05	> \{	seph	emse	1 1 2010
			30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, Pi	int) N.C	lane	ej	St T	wx	on v	M)
Re	Stat egistra	9	31. Date filed SEP 1 4 201	2. Registra	ar's Signatur	par	W			*.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 28729 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 10, Ruth Anne Pfleger 2010 11:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Minnesota **Funeral** 8. Date of Birth Days April 22, Months Hours 340-42-7424 Director 62 1948Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Montgomery Maryland 1 🗌 Yes 2 🗶 No Darnestown 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 12620 Native Dancer Place 20878 United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 Divorced Completed White er than "natur , the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within i Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher County Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Clarence н. Reinecke Ruth н. Kriha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Stephen Pfleger / Husband 12620 Native Dancer Place, Darnestown, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Septëmber Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) 13, 2010 Bethesda, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland Art 1 / there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pancreatic Cancer . Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 🗌 Yes 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending al Director: A 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year, 143201 September 11, 2010

Registrar

DHMH 17 Rev 7/2009

State

6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Deborah Miller,

1 4 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Joseph Powers September 2010 8:22 Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7313 School Lane Baltimore Dundalk Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □XM 2 □ F Months Davs Hours January 3, 1929 214-24-8961 New York Director 81 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Baltimore Dundalk Maryland 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7313 School Lane 21222 USA should be filed within 72 hours after death v n and Mental Hygiene. r is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. þ 1 Never Married 2 Married Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Tin Mill Operator Steel event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Francis Powers Anne Lauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Josephine Powers wife 7313 School Lane, Dundalk, Maryland Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Gardens of Faith 17, 2010 Rosedale, Maryland Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ tronic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Dust to for as a consumumous of and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death certificate be in 24 the funeral Director. After this certificate has been signed by the attending physicis mpleted filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural injury work? 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 | 3 | within 2

To the comple only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D45876 30. Name and ad of person who completed cause of death (Item 23a) (Type, Print) 1920 Campbell Blud, Baltimore, MD 21236 31. Date filed (Month, Day, Year) 32. Registrar State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 2:00p James Charles Ringley Sept Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Woods Nursing & Rehab Cntr. Brinton Sykesville Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Pay, 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral May 17. 1932 Tennessee Director 415-44-1056 78 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Carroll Westminster 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 706 Uniontown Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 A Yes 2 No
If Yes, Give
Year or Dates Korea Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with...
Jental Hygiene.

ed other than "r

the Mr (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Metal Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental H item 27 is marked of William Ringley Donna Mae Goins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2106 Ebbvale Road, Manchester, Maryland 21102 James Ringley, Son other 20a. Method of Disposition
1 □ Burial 2 🏝 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it ō 6 injury 4 Donation 5 Other (Specify) Metro Crematory, Inc. 9/14/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit@remation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dwing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Slasso Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Exami Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death ate has been signed by the apage 2 should be detached Part II. Other significant conditions contributing to death bot not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed r After this certificate 1 ☐ Yes 2 ☐ No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number daddress of person who completed cause of death (Item 23a) (Type, Print) cuter Business u/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Chandula1 Sentember : 27 Joitaram Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore of Hospita N/A Manyland Kaltimore Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 8. Date of Birth Country) India 1 🗓 M 2 🗆 Months Hours Min Dec. 26. 78 220-75-0205 Director 1931 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Reisterstown 10e. Street and Number 5 10f Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 12300 Boncrest Drive 21136 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian Indian 3 🗌 Widowed 4 🗎 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 0 Joitaram Rami Rukshamani Rami 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bharat Rami, Son-in-law 12300 Boncrest Drive Reisterstown Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 9/11/2010 Baltimore, Maryland <u>Metro Crematory Inc</u> 21. Signature of Funeral Service Licensee, Ame 22. Name and Address of Facility MacNabb Funeral Home, P.A. Amanda Heaston 301 Frederick Road Maryland 21228 Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) erebral Edema hours Medical Examine Mass lo days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular accident, hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 24 hours after death. e Funeral Director: After this certificate has autopsy death? Yes 1 Yes 2 No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? ျှ 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar

Rami, Chan dulal

of

Baltimore

ompleted cause of death (Item 23a) (Type, Print)

mai

Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	for State	State of Ma		artment of He				20723		
	Registrar  1. Decedent's Name (First, Mic	idle Last)	Cei	tificate of De	eath		Reg. N2010 28733			
Physician/	Arthur	A .	Ramp1	ev		2. Date of Death Month Sentemb	Death 3. Time of Death 2010 10:25A M			
Medical Examiner	4a. Facility Name (if not institut			4b. City, Town, or Lo	ocation of Death	Бересшь	4c. County of Death			
	Glen Burnie Re			Glen Burn			Anne Aruno	lel		
Funeral Director	5. Social Security Number 204-05-3981	6. Sex 1 X M 2 □ F	(In yrs. last birthday) 88 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 04/19/1	year) 9. Birth Cour	place (State or Foreign htry) MD		
show show	Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, Town or Lo	cation				10d. Inside City Limits		
leath with the Maryland tems 23a or 28a-f sho er must be notified at Ermust be notified at Funeral Director	MD An	ne Arundel		Glen	Burnie			1 Yes 2XXNo		
h the Saor 2	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?		
mus 2.	210 Sandsbur	y Avenue			21060			S.A		
36 fter des maniner by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ N	Armed Forces?	l	Vas Decedent of Hispa Yes, specify Cuban, N	anic Origin? (Spec Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Americ Black, White,			
003 ural", ural",	3 XWidowed 4 ☐ Divord		1	☐ Yes 2 X No S	Specify:		Specify:	Vhite		
21215-003 irithin 72 hours at lene. r than "natural" the Medical Exc		dent's Education ghest grade completed)	(Give I	ent's Usual Occupatio ind of work done durin	on ng most of workin	ng 1	6b. Kind of Business In	dustry		
Vithin liene.	Elementary/Seconday (0-12	College (1-4 or 5-	-) life. Do	NOT use retired)  Truck Dr	river		0112	arry		
nd filed v all Hyg d othe went,	17. Father's Name (First, Middle	e, Last)				(First, Middle, Ma				
ylan Juld be fi Mental narked natic ev	William Rampl	-			Mary D	uncan				
Mar 2 shot th and 27 is n traum	19a. Informant's Name/Relatio		-11				City or Town, State, Zip (	*		
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Mr. John W. R. 20a. Method of Disposition		210 20b. Place of Dispo	Sandsbury			Burnie, Man Oc. Location - City or To	ryland 21060		
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Division of Vital Records, P.O. Box 68760 rate or attending Physician: The law requires that the death certificate bas been signed by the attending physical Director. After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the base or the completed by Physician/Medic	IF FEMALE:									
O. Box 68' I the death certification by the attending stacked for use as Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year		
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ivision of or Attending P after death. Director: After t in by the funera		mined 28e. Place of Injury building, etc.	· - At home, farm, stre Specify)	et, factory, office	21	8f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,		
Di spital ours a ours a neral filled	29a, Certifier 1 <b>O Certifyi</b>	ng Physician: To the best of m	v knowledge death o	Courad at the time, date	o and place and	due to the server	(a) and manner as atota			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate that the fount after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as Medical Certificate: To Be Completed by Physician/Medical Certificate:	(Check 2 L Medical	Examiner: On the basis of examp Nurse Practioner: To the be	mination and/or investi	nation in my opinion de	eath occurred at the	ha time data and r	place and due to the car	scale) and manner stated		
To the within comment	29b. Signature and title of certifi	er		20c License nun	mher	200	Data signed (Month /	Pau Vaari		
	Mark	antino		D-40	05 21	150	eptember	5,2010		
20 41	30. Name and address of person  DR OCHA	who completed cause of dea イミン ことと	th (Item 23a) (Type, Pr	RIVE SOUT	E 208	STEN 6	BURNE, MD	51011		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature Land	,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ 1550 Robert James Stewart, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/ABaltimore 4030 Echodale Avenue Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days (Month, Day, Year) Hours Min. 1 🔀 M 2 🗆 F Months Director 213-32-7056 1935 Carolina Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10h County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at. Baltimore N/A 1 XYes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21206 4030 Echodale Avenue 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Specify Black ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes Give Completed 3 X Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Steel Worker 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Johnson 2 Robert J. Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4783 Shamrock Ave Baltimore, Maryland 21206 Robert J. Stewart, III/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/17410 Burial 2 Cremation 3 Removal from State Laurel, Maryland Maryland National Mem.PK 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home \$240 Reisterstown Rd Baltimore, MD 21215 21. Signature of Saneral Service Ligense It 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or year failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final OCCLUSION Physician/ 1722212V O COM ARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner OROUMNI Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes Yes 21 26. Place of Death (Check only one) Be 25 Was case referred to medical examiner? Other: 2 10 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No (A NIA Accident Investigation filled in by the within 24 hours after deat To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 9-9-2010 GARRISH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 212 ICHARD HUWT MI

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	Type or Print					-		_		
		For State	State of Mar	-				Mental Hy	_	2010	20725	
		Registrar  1. Decedent's Name (First, Middle, Las	<i>t</i> )		Certi	ificate of D	Death	2. Date of D	Reg. No	<u>~UIU</u>	3. Time of Death	
Physicia		Sonet W	Tolls S	lina	d	,		Septem	. D	10 2010		
Medic Examin		4a. Facility Name (if not institution, give	street and number)	- 1	0	4b. City, Town, or	Location of Deat		40	. County of Deat		
Funeral		5. Social Security Number 6. So	X tan P	n yrs. fast birth		If Under 1 Year	If Under 24 Hrs		rth	N/A 9. Bir	thplace (State or Foreign	
Director	1	215-32-5481 <sup>1</sup> Usual Residence of Decedent	_ м 2 [¥ <sub>F</sub> 75	`	Yrs.	Months Days	Hours Min.	May 2	8 YP9	35 Mar	Mand	
and show	JO.	10a. State 10b. County	1	0c. City, Town	or Loca	tion					10d. Inside City Limits	
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tems	Fune	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Wa		spanic Origin? (S n, Mexican, Puert	pecify Yes or No		14. Race - Ame		
after d	व	1 ☐ Never Married 2 🎦 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give	)		Yes 2 No		to rican, etc.)		Black, White, etc.  Specify:Black		
hours natura lical E	letec	15. Decedent's E		16a.	Decede	nt's Usual Occup	ation		16b. Kind of Business Industry   Baltimore County			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. In moortant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest gra	5+ <sup>College (1-4 or 5+)</sup>		ife. DO .cher	NOT use retired)	luring most of wo	rking		Baltimore County  School System		
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or Atter after dea Director in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury building, etc. (	- At home, far Specify)	m, stree	t, factory, office		28f. Location City or To			ral Route Number,	
Hospital Hospital Funeral	Medical	(Check 2 Medical Exami		mination and/or	rinvestig	ation, in my opinio	on, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner stated	
To the within to the To the comple		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of partition (Month, Day, Year)										
		• 6X 108		-M	OD.	100	338	7	Se	ntembe	2,102010	
-		30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Bird Raltimore, MD 21239										
Sta	te	31. Date SE Por 11, 42010	32. Registrar's	ignatur	Ne.		•					

DHMH 17 Rev 7/2009

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		1- State of Mary	land / Depa	artment of Heatificate of De	alth and Me	•	2010 20726
Physicia /Medio	al	1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)  4. Facility Name (If not institution, give street and number)	5n	1. th	5.	Date of Death Month Da Plember 40	y Year 3. Time of Death 3. 70 A M
Examin Funeral Director		The Johns Hopkins Hospital           5. Social Security Number         6. Sex         7. Age (In 2 1	yrs. last birthday) 7 Yrs.	Baltimore C	ity	Date of Birth	3.2 9. Birthplace (State or Foreign Country) MD
with the Maryland 3a or 28a-f show	Funeral Director		c. City, Town or Lo		2		10d. Inside City Limits 1 ▼ Yes 2 □ No  tizen of What Country?  S A
lore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)	16a. Deceo	dent's Usual Occupation	Specify:	16b. l	14. Race - American Indian, Black, White, etc.  Specify: Black  Kind of Business/Industry
yland 2121 buid be filed within Mental Hyglene. arked other than " attic event, the Mer	To Be Completed	Flementary/Secondary (0-12) 12th grade  17. Father's Name (First, Middle, Last) Matthew Smith		ONOT use retired) OMESTIC	3. Mother's Name (i	First, Middle, Maide	railways n Surname)
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Baltimore, permit. Pages 1 ar Department of Hea Important: if item: any injury or other	2 1	4 Donation 5 Other (Specify)  21. Signature of Fundal Service of S	22	2. Name and Address of 1101 E. I	of Facility Mar North Av	ch East venue Ba	
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5 m m m m m m m m m m m m m m m m m m m		30. Name and address of person who completed cause of death PAYAM MOHASSEL	(Item 23a) (Type,	RES-	.000		Stptember 8,2010 St, Baltimore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's S	ignature par	W	000 110		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Doris Ramos Stepanovich 2010 6:25 PM September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Best Care Assisted Living Reisterstown Baltimore Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 9 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2💢 F Months Hours **Director** 457-24-8648 87 923 Texas Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene. ortants if item 27 is marked other than "natural", or items 23a or 28a-f sho ortants if item 27 is marked other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 【XNo Baltimore Maryland Reisterstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 639 Main Street 21136 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes Give 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stenographer Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Grace Isherwood Charlie Monroe Sawyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Court Reisterstown, Maryland 21136 Michael R. Stepanovich, Son Baltimore, 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite cemetery, crematory or other place 4 Donation 5 Other (Specify) Metro Crematory Inc. 09/14/10 Baltimore, Maryland Signature of Funeral Service Licenseen Thomas Gregor Cremation Society Of Maryland, Inc. Frederick Road Baltimore, 21228 Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Approximate Interval Between set and Death Immediate Cause (Final Ph\_sician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 🗆 No Yes 2 N 1 Tes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No injury 1 🕅 Natural 5 Pending 2 Accident
3 Sulcide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Aertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature of certifier 29c. License number 29d. Datę signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add their 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day Physician/ Month Bernadine Slivenski September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Guardian Angel Assisted Living Brooklyn Park 8. Date of Birth (Month, Day, March 1 If Under 1 Year I If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🏻 F 84 Director 217-22-9720 March Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location Director notified 28a-f Pasadena Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 9 Funeral 21122 6 Granada Road Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Mantal Status Armed Forces "natural", or i edical Examin Completed by 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Clerical 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Slivenski Granada Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Sacred Heart of Jesus 2010 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 21. Signatu Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Par 1. Enter the disease, or compleshock, or heart failure. List only ore ations that cannot the death cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ YPERTENSIVE HRTERIOSCIEROTIC CARDIOVASULAR disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of). ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Po ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by Division of Vital Records, progressive dementa, Crestsyndrome, angua pectoris, pulmonary embeli page 2 s has 25. Was case referred to medical funeral director. 26. Place of Death (Chec. Other: 1 Yes 2 🔀 No 4 Nursing Ho 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury\_at 1 X Natural 2 Accident 5 Pending work? 1 □ Yes 2 □ No iours after death.

Neral Director: Af filled in by the fur Investigation 3 Suicide 4 Homicide 6 Could not be

_	23d. Date of delivery
	Month Day Year
	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy performed?  1  Yes 2 No 2 No 24b. Were autopsy findings available prior to completion of cause of death.
on	ly one) Assisted
8d	5 Residence 6 Nother (Specify) Living  Describe how injury occurred  Location (Street and Number or Rural Route Number,
he	City or Town, State)  Le to the cause(s) and manner as stated, time, date and place, and due to the cause(s) and manner stated. Indiduction to the cause(s) and manner as stated.
,	29d. Date signed (Month, Day, Year) 09/13/2010
	LENA MARYLAND 21/22-2014

Year

Anne Arundel

14. Race - American Indian,

Insurance

White

Black, White, etc.

Specify

Birthplace (State or Foreign Country)

10d. Inside City Limits

Onset and Death

1 Tes 2 X No

Maryland

2010

State Registrar

within 24 hours a

To the Funeral I

completed filled

Medical

29a. Certifier

29b. Signature and title of certifier

ANA MARIA MARTINE

MOUNTAIN KOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, ar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place.

2932A

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle | Last) 2. Date of Death Physician/ 3:15 8 10 Medical ne (if not institution, give 4a. Facili **Examiner** street and number or Location of Death 4c. County of Death Baltimore inco Avenue timore Security Number last birthday) If Under If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 1 M 2 KF Months Hours Min. Monta Pay, Yag Director or items 23a or 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. County event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits timore 1 🗆 Yes 2 🔊 lo 10e. Street and Number 10g. Citizen of What Country? Wenue USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 To Specify. Black "natural", Completed 3 Widowed 4 ☐ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NO use retired) al Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumation once. Be is Name (Eirst Middle, Last) 18. Mother's Name (First, Midd ၉ ton 19a. Informant's Name/Relationship (Type, Print) Address (Street and Number or Ru ral Route Numb MD 21228 20b. Place of Disposition (Name of cemelery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, mD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signati re of Funeral Service Lic 23a. Part 1. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart vailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 nse and Death Physician/ METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Year Month Day Pregnant at time of death ed by the a Unknown 9 🗌 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 , 24 hours after death.

• Funeral Director: After this certificate Poleted filled in by the funeral director, pag. 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 5 Pending injury 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State,

State Registrar

DHMH 17 Rev 7/2009

Medical

completed

within 24

29a. Certifier

(Check

only one) 29b. Signature and title of certifie

3 🗆

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STAGNES

CATON

900

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

AVE BALTIMORE

29d, Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10-06499	
Chris Spires	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Chris Spires	1- For State	rland / Department of Health a Certificate of Death		2010 28740
Physician Medical Examine		1. N C 1	2. Date of Deat Month	Day Year
IMEGICAI EXAMINE	4a. Facility Name (if not institution, give street and	vell 501765 number) 4b. City, Town, o	August 28 or Location of Death	4c. County of Death
	8000 Washington Boulevard P65  5 Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24Hrs. 8. Date of Birt	Howard h(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	225-19-2625 1×M 20F	Months Da		1/1977 S. Birtiplace (State of Foreign Country) VA
/ any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	,	10d. Inside City Limits
yland •-f show •nce.	MD Anne Arung	del Glen Burn	ie	1 Yes 2 No
the Maryland a or 28a-f sh tifted at once	192 Plymouth La	OP Ant C 210		og. Citizen of What Country?
2 hours after death with the Maryland "natural", or items 23a or 28a-f show any Examiner must be notified at once. ted by Funeral Director	11. Marital Status 12. Was D  1 Never Married 2 Married Armed		ispanic Origin? ( Specify Yes or No- an, Mexican, Puerto Rican, etc.)	14. Race - American Indian, 8lack, White, etc.
fter dea		2 🗙 No		specify: Black
hours aft inatural Examing	15. Decedent's Education (Specify only highest gr	during most of working lif		16b. Kind of Business/Industry
36 in 7. han lical	Elementary/Secondary (0-12) College	(1-4 or 5+) Labore	20	Warehouse
		T	18.Mother's Name (First, Middle, M	
2121 ould be fi d Mental 1 s marked lic event,		19b, Mailing Address (Stre	eet and Number or Rural Route Num	ber, City or Town, State, Zip Code)
Baltimore, MD openit. Pages I and 2 sho openitent of Health and Important: If item 27 is nijury or other traumati	Eugene Spires Jr /	Father 192 Plyme 20b. Place of Disposition (Name of Co	outh Lane #C	Glen Burnie, MD 2061  20c. Location - City or Town, State
altimore, mit. Pages I ar partment of Hee pportant: If ite jury or other tr	1 X Burial 2 Cremation 3 Removal	and the second s	1 (	Chesapeake, VA
Baltir permit. E Departme Importar injury or	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Addres	ss of Facility 5151 BA	LTIMORE NATLAIL
Physician	23a. Part I. Enter the disease, or committees that	caused the death. Do not enter the mode of dying	TIMOKE, MD	
/Medical Examiner		rtensive Cardiovascula	r Disease	Between Onset and Death
pr. 11	or condition resulting in death)  Due to (or as Sequentially list conditions,	a consequence of):		
niner		a consequence of);		
ted insit Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as	a consequence of):		
o,  e be executed sician and burial - transit	▼ UNPENDED	23a,pt.II,27 per me	g908 10-13-10 <b>v</b> t	
8760 tificate I ng phys as the bu	IF FEMALE: 23b. Was decedent pregnant in the 1 Live	outcome of pregnancy birth 2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery  Month Day Year
b. Box 6876( the death certificate the attending phy ched for use as the the Physician/Me	past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown	gnant at time of death 5 Other (Specify)		
res that the d signed by the be detached		to death but not resulting in the underlying cause		pacco use contribute to the cause of death?
ords, P.( w requires tha s been signed should be det	Morbid Obesity, Chro	nic Lung Disease	1 Yes	
Records, The law requires fficate has been sig page 2 should be Completed			autops	y prior to completion of cause of death?
Vital Recyssician: The his certificate director, page	25. Was case referred to medical	26 Plac	1 Yes 2 e of Death (Check only one)	No 1 Yes 2 No
f Vit Physici er this c rral dire To E	examiner? 1 Very 2 No  27. Manner of Death 28a. Dat	Inpatient 2 ER/Outpatient 3 DOA e of Injury 28b, Time of Injury 28c, Inju		Residence 6 Other: Scene
ion of tending Pheath.  In After the funeral the funeral attion: T	1 X Natural 5 Pending (Mon	th, Day, Year)	Yes 2 No	ow injury occurred
Division of Vital Records, P.O. sprial or Attending Physician: The law requires that the rours after death.  Ineral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detead Certification: To Be Completed by F	2 Accident Investigation 3 Suicide 6 Could not be determined (Specification of the determined)	ice of Injury - At home, farm, street, factory, office	building, etc. 28f. Location (St or Town, Sta	reet and Number or Rural Route Number, City ate)
Division of Vital Records, P.O. Box 68766  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beneficial Certification: To Be Completed by Physician/Me	29a. Certifier (Check only one) 2 Medical Examiner: On the basis	est of my knowledge, death occurred at the time, d		
Z S S S S S	and manner 29b. Signature and title of certifier	29c. Licens		29d. Date signed (Month, Day, Year)
	30 Name and address of severe	O.C.	M.E.	August 29, 2010
r	30. Name and address of person who completed car Donna M. Vincenti, MD Assistant		, Baltimore, MD 21201	73
State Registrar		tegistrar's Signature		
DHMH 17 Rev 1/2001	OCME	ORIGINAL		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month KENERSON GLAZE JACKIE 0430 O 04 2010 lity Name (If not institution, give street and number)

1 13800 McMullew Highway, Sw 4b. City, Town, or Location of Death 4c. County of Death CUMBERLAND ALLEGAN 5. Social Security Numberunk If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 unk Days Hours 1**∑** M 2□ F 79 Yrs Mar 4, 1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany 1 ☐ Yes 2 ☐ No Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13800 McMullen Hgwy SW 21502 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. unk 1 Never Married 2 Married unk 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Western Correctioninal Inst 13800 McMullen Hgwy Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖺 Other (Spacify) in state 21. Signa and of Funeral Service 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street > Baltimore, MD 21201 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a CHRONIC OBSTRUCTIVE PULMONARY Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

**Physician** /Medical Examiner

death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Page Department of Important: If any injury or once.

**Physician** 

/Medical

Examiner

Director

þ

Completed

Be

unk

MD

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other then "natural", or Items 23a or 28a-f show ury or other traumatic event, "he Madical Examinal must be notified at

altimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be P

signed by the attending physician and d be detached for use as the burial-transit page Certification:

After this certificate has

Director: /

Hospital or Attending Physician:

death.

efter

To the Hospital within 24 hours or To the Funeral Completely filled

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

4 Homicide

29b. Signature and tipe of certifie

29a, Certifier

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 1 Inpatient 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 3 Suicide 6 Could not be determined

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

29c. License number

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 09-04-2010

Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

1 ☐ Yes

28d. Describe how injury occurred

26. Place of Death (Check only one)

30. Name end address of person who completed cause of eath (Item 23a) (Type, Print) 13800 MEMULEN HIGHWAY CUMBERLAND, MD 21502 ててど

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ 9:20 PM September 10 SMITH 2016 FLORENCE Medical 4c. County of Death City, Town, or Location of Death Facility Name (if not institution, give street and number) **Examiner** Baltimore N/A Hospi ta 8. Date of Birth If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs **Funeral** 05/27 74 921 Hours Min. Country) 1 M 2 GF 89 214-14-5802 **Director** Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2x No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21208 USA 3200 LIGHTFOOT DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 X Married Yes 2 X No Yes, Give Completed by WHITE 1 ☐ Yes 2 🔀 No Specify: 3 🗌 Widowed 4 🗆 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Baltimore, Maryland 2121 Elementary/Seconday (0-12) OWN HOME HOMEMAKER 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ KLEIN ANNE LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3200 LIGHTFOOT DRIVE, BALTIMORE, MD LEONARD SMITH/HUSBAND 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 9/13/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign, tur f Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final months Physician/ disease or condition resulting in death) Medical Du to (or consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and I for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death certificate has been signed by the a rector, page 2 should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Dertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autons death? 2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ည Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar 29b. Signat

and title of certifier

31. Date filed (Month, Day, Year)

Hallmar

SEP 14 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sinai Hospital of

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Toroni September 10,2010  $A^{M}$ Wallace Joseph 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs, last birthday) **Funeral** 1**X** M 2 □ F Days Hours Min Oct. 17, 1923 Pennsylvania **Director** 197-12-1215 86 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director 1 🗆 Yes 2 ី No Timonium MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 200 Charmuth Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify:White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Baltimore Symphony College (1-4 or 5+) 5+ Cellist Orchestra Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SEPTEMBER 10, Henry Toroni Assunta Garzia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, MD 21093 Anne D. Toroni/Wife 200 Charmuth Road 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date Sept. 2010 15, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD eral Service Lidensed <sup>22. Name and</sup> Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signatur of Fryan W Cl*a*ry 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur i. List only one cause on each liv. Approximate Interval Between Immediate Cause inal disease or condition resulting in death) Onset and Death Physician a 90 Months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L Fetal uea Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year ate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. License number 29b. Signature and title of certifier 29d, Date-signed (Month, Day, Year 52 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD WRIGHT, TIMONIUM MD 21093 ERNESTINE  $M_{\bullet}D$ 31. Date filed (Month, Day, Year) 32. Regis

State Registrar

10:00 A.M.

WALLACE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $r^{\text{Day}}$ 3, Physician/ 2010 1:56 September Antonio Tijman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 5802 Nicholson Lane #L03 Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Social Security Number Hours October 29, 1 🔀 M 2 🗆 F Days 1921 Director 88 Buenos Aires 220-35-7056 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 5802 Nicholson Lane #L03 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Argentinian White Specify: permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Execution. "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Service 5+ Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Tijman Maria Fuks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8007 Custer Road, Bethesda, Maryland 20814 Horacio Tijman/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 14 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Remembrance 4 ☐ Donation 5 ☐ Other (Specify) 2010 Clarksburg, Maryland Robert A. Pumphrey Funeral Home/Chevy Chase, Ind M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service License Inc Haran 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Day shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner 18 Months Mesothelioma Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? Yes 2X No certificate To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 □ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica! Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of pg

Charles Picone,
31. Date filed (Month, Day, Year)

SEP 1 4 2010

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D

56065MD

5530 Wisconsin Avenue #930, Chevy Chase, Maryland 20815

September 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Kenneth 2010 Turner 12:32 PM **Physician** tembe /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F 13, 1952 Maryland 58 Director 215-58-2250 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any Injury or other traumatic event, the Medical Examiner must be notified at once. Yes 2 No Funeral Director Maryland Harford Aberdeen 10f. Zip-Code 10e. Street and Number 10g, Citizen of What Country? 902 Oxford Avenue 21001 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) VA Medical Center Assistant Fire Chief 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Roy Lee Turner Nancy Irene Worrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Oxford Ave., Aberdeen, Maryland 21001 Julie Ann Sang / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 XCremation 3 Removal from State Hilltop Service Corp. 9-13-10 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature McComas Funeral Home, P.A. Funeral/Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic Immediate Cause (Final disease or condition resulting in death) neuroendocrine **Physician** /Medical Due to (or as a consequence of) **Examiner** Mari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) DOWE the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Ectopic pregnancy Live birth Month in the past 12 months? Pregnant at time of death 2 No 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Thpatient ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Waturai 1 Yes 2 No Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 24061 10V ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State Registrar

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Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	118		terstown	Rd, Re:		own, MD 21136
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State Registrar DHMH 17 Rev 1/2001

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	If ite		20a. Method of Disposition  1 XBurial 2 X Cremation 3	Removal from	State Gr	Place of Disp	pher pla	ice)		Date		Location - City		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	the attending physician ted for use as the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, out	come of pre-	gnancy			Ectopic pregn		23	3d. Date of delive	ery Day Yea	ar
<b>x 68</b> th certi	tending r use as	siciar	past 12 months?	4 Pregnan	t at time of d		Fetal dea Other (S	_				WOTE	Day 100	, cui
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Division tal or Attendii rs after death.	Director: I in by the	tifica	2 Accident Investiga  3 Suicide 6 COuld no	t be 28e. Place of	of Injury - At I	nome, farm, st		ory, office bu	uilding, etc.	28f. Locatio or Town	n (Street	and Number or F	Rural Route Numbe	er, City
Di ospital	y filled	ပ	4 Homicide  29a. Certifier 1 Certifying Physic	1-437		in al				Heigh	its A	ve. Bal	to City,	Md.
Division  To the Hospital or Attend within 24 hours after death.	To the Funeral Dir completely filled in	Medical	(Check only 1 Certifying Physic one) 2 Medical Examine	er:On the basis of	examination	dge, death oc and/or investi	curred at gation, in	the time, dat my opinion,	te and place, an death occurred	at the time, da	ause(s) a ate and p	nd manner as st lace, and due to	ated. the cause(s)	
To	F S	Me	29b. Signature and title of certifier	and manner stat	<u> </u>	<del></del>		29c. License	number		29d.	Date signed (N	fonth, Day, Year)	
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ch perd			30. Name and address of person who Ling Li, MD Assistant I	completed cause Medical Exami		<sup>n 23a)</sup> 1 Penn Str	eet, Ba	altimore, N	MD 21201					
	Sta	ate	31. Date filed SEP 1, 4 201	3 Regis	strar's Signa	. pa	12.1	,						
R	egisti	rar	API T - COI	· LEWY		. 14 60	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vicker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** (Month 214-64-2043 59 Director September 8,1951 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location death with the Maryland "natural", or items 23a or 28a-f sho Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code Funeral 21222 55 Wise Avenue Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or any injuy or other traumatic event, the Medical Examin þ ☐ Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fire 2 Thelma Hu Elmer Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro 55 Wise Avenue, Dundalk John Vickery Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Septer 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 17, 20 Signature of Fundal Service Lice 22. Name and Address of Facility Connelly Funeral Home 7110 Sollers Point Ro 23a. Part 1 Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pnysician/ ulmm Medical resulting in death) Due to (or as a consequence of): Examiner Metasta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 3 ☐ Ectopic pregion 5 ☐ Other (specify) ☐ Pregnant at time of death☐ Unknown 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

of Decedent												
10b. County		10c. City,	, Town o	r Location	า							10d. Inside City Limits
Baltimore		D	Dundalk								1 ☐ Yes 2 【XNo	
ımber		L		10	f. Zip Code				100	a. Citiz	en of What Co	ountry?
Avenue					212	22			1.00	-	SA	,
	/as Decedent B	aror in II S	-	13 M/as F	Decedent of F		Origin? (Sp.	ocify Ves	or No-	<del>-</del>		ulana la dina
Α Α	rmed Forces?				specify Cub					'	<ol> <li>Race - Ame Black, Whit</li> </ol>	
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15. Decedent's Education	ear or Dates.		160 D	ooodont'o	Usual Occup	nation		_	140			I de de
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NIM	1	I Alexandread	De								lk,Md.	21222
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ficant conditions contribu	ting to death b	ut not resu	ılting in t	he underly	ying cause gi	ven in Pa	art I.	236	e. Did tobac	cco us	e contribute to	the cause of death?
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5 Pending Investigation	(month), Day	, , , , , ,	- inju	M		Yes 2	□ No					
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determined	building, etc	. (Specify)							or Town, S			
Certifying Physician:	To the best of	my knowlo	dae do	ath occur	ed at the time	data ar	nd place on	nd due to	the caused	s) and	manner as str	ated
Medical Examiner: O	n the basis of e	xamination .	and/or in	vestigatio	n, in my opini	on, death	occurred at	t the time	, date and p	olace, a	and due to the	cause(s) and manner stated
Certifying Nurse Practition	ctioner: To the	best of my	knowled	ge, death				ce, and du				
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th, Day, Year)	32. Registra	ar's Signatu	ire -		1	- 40	- (	, w.	, ,	-	V C. W.	
P142010	Victoria .	B	Ja.	a Kan	9							

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4c. County of Death

N/A

0034 AM

9. Birthplace (State or Foreign

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician;

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Completed

Be

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Certificate:

Medical

25. Was case referred to medical

2 🗆 No

examiner?

27. Manner of Death

1 🗷 Natural

☐ Accident ☐ Suicide

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) s. Bessma MO uns 31. Date filed (Month, D Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September -12:23P MELVIN **ARTHUR** VanDANIKER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days Hours Min (Month, Day, Year) 09-23-1926 M 2 🗆 F Maryland **Director** <del>220-14-7347</del> 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 🌠 😾 No Maryland Baltimore Cockevsville ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8 Highfield Court 21030 USA 12:23 p.m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

XXX Yes 2 \sum No WW I I Black, White, etc 5 ģ 1 Never Married 2 X X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify. White "natural", Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Diesel Mechanic Golf Course injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph VanDaniker Ida Cook September 9, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmela P Madore DTR 1023 Trickling Brook Road Cockeysville Maryland 21030 Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Dulaney Valley Mausoleum 1 XD Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 09/14/2010 Timonium, Maryland ce Licens Signature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 . Part 1. Enter the disease, or complice shock, or heart failure. List only one dons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Onset and Death Immediate Cause (Final Ph sician/ LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No detached g [] Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ within 24 hours after deam.

To the Funeral Director: After this certificate has Leen signs completed filled in by the funeral director, p. ge 2 should be it 2 ☐ No 3 ☐ Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🕱 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Melvin Van Daniker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#10e, perFH, G907, 9/14/2010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 16:07 errence 2010 estember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Boyvier Medical Hoplins Baltimore Lenter N/A 6. Śex 1 M 2 □ F 8. Date of Birth
Jan • 13 Year) 963 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Mary Tand Director 422-90-1766 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 🖁 No N/AMartinsburg W.Virginia 10f. Zip Code 20 Lippiza Ct. 10g. Citizen of What Country? <del>#506</del> 25405 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 11th grade College (1-4 or 5+) Food Service Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Geraldine Witt John H. Watson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 E. Stephen St#506 Martinburg, W.VA 25401 John H. Watson, Jr./Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important; If ite any injury or oth 1 🔲 Burial 2 🔁 Cremation 3 🗀 Removal from State 9/9/2010 Greenmount Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman—Harris Funeral Home Signature of Funeral Service Lice 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Depsis disease or condition resulting in death) 3 day Medical Due to (or as a consequence of): Examiner Bowe Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month 1 Yes 2 9 Unknown 2 🗌 No Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ IX Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No X Natural Accident
Suicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 000 30. Name and address of person sho completed cause of death (Item 23a) (Type, Print) 21224 D.0 4940 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 12 Physician/ 2010 06:35 PM Wilson-Lathroum Trene Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Futurecare Chesapeake Arnold 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 StF Months Hours Jan. I6 1920 214-16-9369 90 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Anne Arundel Arnold Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 815 Windsor Road 21012 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc by 1 Never Married 2 Married ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Food Retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ George C. Link Carrie Μ. Gerberick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Wilson 815 Windsor Road, Arnold, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Sept. 2010 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 18 Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) Stallings Funeral Home, P.A. 21. Signature 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate 23a. Part 1. Enter the dis shock, or heart failure List only one Interval Between Onset and Death Immediate Cause (Final Physician/ カ・ハノナマ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, seeing to immediate cause. Enter Underlying Examine Due to lor as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregi 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached f significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Linknown Completed 24a. Was an 24b. Were autopsy findings available autopsy has death? certificate Yes 25. Was case referred to \_\_\_\_cal 26. Place of Death eck only one) Be examiner? 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မြ hours after death. 28a. Date of injury (Month, Day, Year) funeral 27. Manner death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 atural 5 Pending Investigation Accident the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu

State Registrar e and address of person who

31. Date filed (Month, Day

pleted cause of death (Item 23a) (Type, Print)

32. Regis

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5PM 010 ence ep 1 Medical 4b. City, Town, or Location of Death Examiner owar . Age (In yrs. last birthday) 8. Date of Birth Funeral Sex 1 

M 2 □ F Months onth, Day, Director 2 ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Yes 2 No e WOOD 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country Funeral 21040 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes Give Specify: Completed 3 Divorced 4 Divorced ack Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industr (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) Honard Be 17. Fathes's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or 19b. Mailing Address (Street and Number Barbara 21040 Jean Williams 312 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State cemetery, crematory or other pla 4 Donation 5 Other (Specify) 13-10 22. Name and Address Yaughn 5151 Bal 21. Signature of Funeral Service Licensee Greene hmore 23a. Part 1. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate has Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? twokey Hospital: Other: 1 Tes 2 No မှ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury 1 Natural 5 Pending Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wallington Month **Physician** Brice 10:11 a.M ptember 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPItal Baltimore he Johns HOPKINS If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland anent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show try or other traumatic event, II. "It also a mercan and the promitted at ury or other traumatic event, II." The fine IE with remained to a page. 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State 1 Yes 2 □ No **Funeral Director** saltimore 10g. Citizen of What Country? 10f. Zip Code 10e. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: Black Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Sanitation Oth 18. Moțher's Name (First, Middle, Maiden Surnan 17. Father's Name (First, Middle, Last) Mallinaton ဂ 19b. Mailing Address (Street and Number or Rural Route Imber, City or Town, State, Zip Code) Craddock HYENUE Wallingtor Method of Disposition

1 Description | Method | Proceedings | Proceedings | Procedure | Method | Procedure | Method | Procedure | Procedu 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State Date 3 Removal from State permit. Pages Department or Important: If i any injury or once. 21. Signatur of Europe 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arterioscleratic Cardiovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death
9 Unknown 5 Other (specify) detached 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 4 Unknown 3 ☐ Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 ☐No Division of Vital 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 6 completely filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 8, 2010 RES-000

State Registrar 30. Name and addre

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

ORIGINAL

600 North Wolfest Baltimore, MD 21287

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

rle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28754 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Q** Day Physician/ Leon Vernon Wink Sr. 2010 1:03 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Worcester Ocean City 13330 Peach Tree Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🔀 M 2 🗆 F Days Hours 10/23/1936 73 212-34-1108 Director Usual Residence of Decedent shov 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State Director ral", or items 23a or 28a-f s Examiner must be notified Ocean City 1 X Yes 2 No Worcester MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA Road 21842 13330 Peach Tree Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Black, White, etc. X Yes 2 ☐ No ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. Fire Department life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other tl any injury or other traumatic event, the once. Fire Fighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Pyffer Wink Marie Downey 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7008 Carmae Road Sykesville MD 21784 Dawn Snyder/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 9-13-2010 Brooklyn MD C**¢**dar Hill Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, F Feral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line nterval Between Onset and Death Immediate Cause (Final Non-Smell Cell Physician/ tastanc disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or, Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Year Pregnant at time of death ed by the a q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by pe 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons certificate has 1 ☐ Yes 2 ☐ No Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) this 27, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c, Injury at s after death.

I Director: After to in by the funeral 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No 1 📇 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Hospital 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one)

Registrar

title of certifie

Naai

29b. Signature

ss of serson who completed cause of death (Item 23a) (Type, Print) 100

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryla				Mental Hyg	jiene	10 28755
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	Jeatn	2. Date of Dea	Reg. No.	
	Physicia			Cm			Sept. 1	Day	3. Time of Death 9:02 P M
	Medic		Ronald D Wright  4a. Facility Name (if not institution, give street and number)	Sr.	Ab City Town or	Location of Death		4c. County	
	Examin	er	1702 Park Avenue		Haletho			1 '	timore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	g Birthplace (State or Foreign
	Director	2	217-34-5006 1 <sup>1 ⊠ M 2 □ F</sup> 71	Yrs.	Months Days	Hours Min.	Oct. 6,		Maryland
	>		Usual Residence of Decedent						
	f sho	tor	10a. State 10b. County 10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a- otifie	irec		lethor	oe				1 ☐ Yes 2 🔀 No
	h the kaor ben	al D	10e. Street and Number		10f. Zip Code				What Country?
	ns 23 must	Funeral Director	1702 Park Avenue		21227			USA	
	r iter iner		11. Marital Status  1 □ Never Married 2 ☒ Married  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 ☒ No		Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American Indian, ick, White, etc.
95 95	after al", o xam	d b	3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify	white
Ž,	nours latura ical E	Completed by	15. Decedent's Education	16a, Deced	lent's Usual Occup	ation		16b Kind of B	Business Industry
2 2	n 72 h an "n Med	mp	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)		kind of work done c O NOT use retired)	during most of work	ing	TOD! TIME OF D	abilioso illadoli y
7	withir giene er tha		12	Quali	ity Contr	ol Superv	visor	applian	ices
g	al Hy d oth		17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, I	Aaiden Surnam	ie)
<u>a</u>	ould be filed within 72 hours after death with the Maryland Id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	욘	Roy T. Wright			Anna Lou	uise Dul	in	
Baltimore, Maryland 21215-0036	an is		19a. Informant's Name/Relationship (Type, Print)			and Number or Run nue, Hale			
<u>~</u>			Barbara A. Wright						
0	ye 1 a t of h If ite or ott	1	1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State	Place of Dispo centery, cren	natory or other plac	:e)	Date		- City or Town, State
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Ra	permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other t	1	21 Signatur of Funecal Surviva Licensee	$\frac{22}{13}$	Name and Address Sulph	ss of Facility Aml ur Spring	rose Fu	neral H rbutus	Home Inc. MD 21227
			23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	ath. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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	Medical Examiner		resulting in death)  Due to (or as a consecutive conse				,	- /	
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	ed isit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	quence oi):					
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2	be e	ical	d						
و کر	ficate ig phy as the		IS SERVICE.						
200	endin	an/I	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnant   1	nancy stal death 3 🗆	Ectopic pregnanc	ev		23d. Da	ate of delivery
ROX	death	Physician/Me	1 Yes 2 No 4 Pregnant at time of		Other (specify)			Mo	onth Day Year
j.	it the I by ti stach	Phy	g Unknown  Part II. Other significant conditions contributing to death but not re	sculting in the u	nderlying cause air	(en in Part I	OO Did to	una cont	tribute to the cause of death?
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20	equin een s rould	etec							
Vital Records,	law r has b e 2 st	Completed					24a. Was a	sy	Were autopsy findings available prior to completion of cause of death?
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<u>o</u>	ician certifi rector	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1   Inputient 2	_	Othe	ace of Death (Chec			
0 \	Phys	.To	1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of injury	☐ ER/Outpatien 28b. Time of	t 3 🗆 DOA	4 ☐ Nursing Ho	ome 5 🔀 Reside 28d. Describe ho		
Ē	nding th. : After	cate	1 ► Natural 5 □ Pending (Month, Ďay, Year) 2 □ Accident Investigation	injury	work	? Yes 2 \Bar No	Zou. Describe ne	w injury occurr	
<u>s</u>	Atter	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At h		et, factory, office	-			per or Rural Route Number,
UIVISION	tal or rs afte al Dir		bullding, etc. (Speci	ry)			City or Towr	, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my know 2 Medical Examiner: On the basis of examination	on and/or invest	igation, in my opinio	on, death occurred a	it the time, date an	d place, and du	ue to the cause(s) and manner stated.
	To the within To the Comp	2	29b. Signature and title of certains	,,	29c. License	number	2	9d Date signer	nd (Month Day Year)
			Dell'UNS			34517		2501	4 13 2010
	8		30. Name and objects of person who completed cause of death (liter	m 23a) (Type, P	rint) do.	4100 e.	Anor 14	ono?	2111
I	Stat	Ç	31. Date filed (Month, Day, Year)  SFP 1 4 2010  32. Registraris Sign	ative	)				
	Registra		SEP 1 4 2010 General B. &						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 12, 2010 Physician/ 6:25 Velva Ellen Weeks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville 14014 Parkvale Road 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. December 11. Virginia 70 227-50-1959 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20853 2505 Baltimore Road, #4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married by 1 Yes 2 X No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Tech Defense Contractor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Gazelle Robertson General Jewe1 Weeks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14014 Parkvale Road, Rockville, Maryland 20853 / Sister Donna Russell 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) September 1 X Burial 2 Cremation 3 Removal from State Beaver Creek Cemetery Floyd, Virginia 17, 2010 4 Donation 5 Other (Specify) 21. Signatu e of Funera e ervi le Licensee Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 A W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1 Month Immediate Cause (Final Metastatic Breast Cancer to Lung and Pleura Physician/ disease or condition resulting in death) Medical Examiner Prior Early Stage Breast Cancer 4 1 Years Sequentially list conditions Examiner Due to (or as a consequence oi) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Vear Pregnant at time of death s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performed?

☐ Yes 2 X No 1 Yes 2 No After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \triangle \text{Nursing Home} \) 5 \( \triangle \text{Residence} \) 6 \( \triangle \text{Other} \) (Specify) Residence Hospital 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifier

hin 24 hours a the Funeral D mpleted filled i

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one M7 29b. Signature and title of 29d. Date signed (Month, Day, Year) September 13, 2010 D0037236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 Rockledge Drive, #506, Bethesda, Maryland 20817 M.D. Carolyn B. Hendricks,

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature SEP 1 4 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 2010 6:25 Frank Wiggins September Norman Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Chevy Chase 6657 Fairfax Road 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1<u>947</u> Funeral July 22 Days Min. 1 X M 2 □ F California 479-56-3569 63 Yrs **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at gones. 10c. City, Town or Location 10b. County 10a. State Director 1 ☐ Yes 2 🛣 No Chevy Chase Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20815 United States 6657 Fairfax Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Force Black, White, etc. 1 X Never Married 2 Married 2 X No þ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Specify: Caucasian Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Venable LLP. 5+ Lawyer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dorothy Greenway George Norman Wiggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chevy Chase, Maryland 6657 Fairfax Road Dianne Elkin / Companion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 13, 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland Montgomery Crematorium Inc 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda - Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 0 M01596 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final Physician/ disease or condition YIE Medical resulting in death) Due t (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or se a consequence of; attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year been signed by the atte should be detached for Day Pregnant at time of death Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: in 24 hours after deaun. he Funeral Director: After this or roleted filled in by the funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No ၉ 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 Natural 2 Accident work 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of İnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined cal Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practice: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. only one) 29d. Date signed (Month, Day, Year) Signature and title of cofficer 2010 N00428 MODINE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Ira N. Brecher,

SEP 1 4 2010

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

524 Hawkesbury Lane Silver Spring, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 8, Physician/ 2010 2:37 РΜ Maria C. Wheatle Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Rockville 810 Wade Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🏻 F Months Days Hours (Month 8, 1935 Equador 578-78-0618 74 December Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a, State 10h County Director notified 1 X Yes 2 No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò Examiner must be Funeral 23a 20851 United States 810 Wade Avenue "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 White 1 X Yes 2 □ No Specify: Equadorian 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Hospital Laundry 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clemencia Francesca Chango Jose Leno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 810 Wade Avenue, Rockville, Maryland 20851 Wheatle / Husband Carlos W. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State September Silver Spring, Maryland Gate of Heaven Cemetery 14, 2010 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Signature of Fun I Service Licenses M01305 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death P.O. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, he/mers 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical examiner?

1 X Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pendina 1 🗌 Yes 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practionar. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 100 m mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRKKER MOOME 31. Date filed (Month, Day, Year) 32. Registrar's Şignature

DHMH 17 Rev 7/2009

State

Registrar

1 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT ALFRED WELLS EPTEMBER 2010 :00 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD Social Security Number 6. Sex. 1 M 2 F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Maryland Months Days Hours Min Aug. 16 86 Director 219-18-6001 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🟋No Harford Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21014 USA 501 Underwood Lane within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces
1 X Yes 2 [
If Yes, Give
Year or Dates. Black, White, etc "natural", or þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Education Math Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lillian R. Weinkam Alfred (unk) Wells Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other training. David Wells / Son 3532 Honeysuckle Lane, Baltimore, Maryland 21220 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Hilltop Service Corp. 9-13-10 Towson, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. rentes a 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease of shock, or heart failure. List natications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final end soay Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin g physician and s the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease of linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as t the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death signed by the a 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page performed' 2 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time. date and place, and due to the cause. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) D32299 Sept. 7, 2010

Registrar
DHMH 17 Rev 7/2009

DAVID DUNN

31. Date filed (Month, Day, Year)

21014

BEL AIR, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Wexler 2010 Marion 2:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Stella Maris Hospice 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Month, Day, 15, 1927 Maryland Director 214-24-9383 82 Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore Dundalk 1 ☐ Yes 2 🔀 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r by Funeral 21222 USA 8152 Midhaven Road tems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Force Black, White, etc. 1 Never Married 2 Married 2 🔀 No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Salon Beautician 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Page 1 and 2 should be f ment of Health and Menta ant: If item 27 is marked Madelein Lambelin William McCann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21222 19a. Informant's Name/Relationship (Type, Print) 8131 Parkhaven Road, Dundalk, Maryland Marty Reynolds Daughter Department of Healt Important: If item 2 any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Middle River, MD. Holly HIll Memorial 14, 2010 re of Funeral Service Licensee ്റ്റിണ്ടിസ് സ്ക്രീട്ടിയില് Home Of Dundalk,P.A. 7110 Sollers Point Road, Dundalk,MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No page 2 should be detached for 5 Other (specify) Month Day Year Pregnant at time of death been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform hours after death.

Ineral Director: After this certificate 2 🗌 No Yes 2 K No 1 Tes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\blacksquare$  Other (Specify) **HOSPICE** 1 Tyes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

**JACKIE** 

31. Date filed (Month, Day, Year)

JONES,

CRNP

a.m.

2:30

SEPTEMBER 11,

MARION WEXLER

2300 DULANEY VALLEY RD.

32. Registrar's Signatur

TIMONIUM.

MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland /	-			Mental Hy	giene	10	20761
			State Registrar		Certif	icate of D	Death	T	Reg. No.	)   0	20101
Př	nysicia	n/	1. Decedent's Name (First, Middle, Last)	V				2. Date of De Month	. Day	Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give st	YOUNGER			Location of Death	Septem		2010	7.05
•	xamin	er	10.116.1 ME no		70/	BO 17	TMORE		4c. Cou	nty of Death	
Fu	ineral		5. Social Security Number 6. Sex	RIRL HOSPIT, 7. Age (In yrs. last b.		Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthp	lace (State or Foreign
	ector		217-34-4817 18	M 2 $\square$ F 7. Age (In yrs. last b.	Yrs. M	onths Days	Hours Min.	(Month, Da	- 1938	MAL	PYLRUD
	No.		Usual Residence of Decedent  10a. State 10b. County	10. O't. T-					<u>-</u>	1.	0.1.1.000.1.1.000
rylan	ieda	cto	Noa. State	-2	wn or Location	0					0d. Inside City Limits 1 Yes 2 □ No
e Ma	r 28a notif	Dire	10e, Street and Number	10RL	TIM	10f. Zip Code			10g. Citizen	of What Coun	
vith t	23a c st be	raf	y	R RYENUE		210	15			5.R.	ay:
death with the Maryland	ems er mu	Funeral Director		2. Was Decedent Ever in U.S.	13. Was	Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		lace - Americ	an Indian,
fe d	or if	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		s, specify Cubai	n, Mexican, Puerto	Rican, etc.)		llack, White,	
UUS after	ural"	ted	3 Widowed 4 Divorced	Year or Dates.					Spec	BL	RCK
13-0030 72 hours after	edic	Completed	15. Decedent's Edu (Specify only highest grade		(Give kina		ation Juring most of work	ing	16b. Kind o	Business Inc	dustry
ithir A	r thar	ပ္ပ	Elementary/Seconday (0-12)	College (1-4 or 5+)		OT use retired)	OFFICE	-0	1 mil	ELIE	RCEMELIT
Fe S	othe ent, 1	Be	17. Father's Name (First, Middle, Last)		IKIK.	77700	18. Mother's Nam		Maiden Surna		WET JENT
be fi	rked fic ev	욘	ROY CLIFTON YO	UNGER SE			WILLIA	E FAT	HFR)	TISM	2/E
should and N	s ma		19a. Informant's Name/Relationship (Type		9b. Mailing A	Address (Street a	and Number or Rui				code)
and 2 s Health	n 27 ier tra		ROY CLIFTON YOU	LIGERTIT SON A	4812	LANIK	ER PESEBP	Jimo	eć. Mi	0212	.15
e de le	Important: If item 27 is marked other than "haturah", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 ABurial 2 Cremation 3 R			ory or other place	e)	Date	20c. Locatio	n - City or To	
mit. Page	tant:		4 ☐ Donation 5 ☐ Other (Specify)	Lou	DON	PRRK	19-1	5-2010	BRI	Timok	E, MD ES FH, P.A.
Dalling permit. Pag Department	any ir		21. Signature of Funeral Service Licens	_	22. Na						
		Н	23a. Part 1. Enter the disease, or complic	cations that caused the death. Dr	not enter th					_/ . /Y//	) 2 12 15 Approximate
			shock, or heart failure. List only one Immediate Cause (Final	cause on each line.			y,		,		Interval Between Onset and Death
Physi Me	edical		disease or condition resulting in death)	Due to (or as a consequence	Sep?	Sis				-	2 days
Exa	miner			Osteomu		S					1 week
	*,	iner	Sequentially list conditions, bif any, leading to immediate cause. Enter Underlying	Due to (or as a consequen-		rest ne	65%				~ _
J. E. E.	and -transit	xam	Cause (Disease or iinjury that initiated events c	_ Uncontrolle		iabet	-es				~ 5 years
Ite be executed	nysician and he burial-transit	dical Examiner	resulting in death) Last	Due to (or as a consequence	e of):						
cate b	the k	edic	d d								
Sertific S	ise ag	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					23d.	Date of delive	erv
death	d for t	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal dea 4 Pregnant at time of death		ctopic pregnanc ther <i>(specify)</i>	у				Day Year
thed	ache	hys	9 🗆 Unknown	9 Unknown							
s that	gned oe def	þ	Part II. Other significant conditions con	tributing to death but not resulting	g in the unde	erlying cause giv	en in Part I.				e cause of death?
Squire S	onld b	ted						1 🗆	Yes 2 ∐ No	3 ∐ Prob	pably 4 Munknown
e law requires	as De	Completed						24a. Was auto	psy	prior to cor	osy findings available mpletion of cause of
E H	cate:							1 \(\sum \) Yes	ormed? 2 No	death?	2 🗌 No
y I La I	recto	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:		Louis	ace of Death (Chec er:				
g Phys	eral di	e: To	27. Manner of Death		. Time of	28c. Injury	4 L Nursing H	ome 5 L Resi 28d. Describe			
nding	e fun	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 ☐ No				
or Attendir	by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street,	factory, office		28f. Location (		nber or Rural	Route Number,
italo L	led in		A								9
To the Hospital or Attending Physician: The law requires that the death certification is a fler death.	rune sted fi	Medical	(Check 2 Medical Examine	cian: To the best of my knowledge er: On the basis of examination and	d/or investigat	tion, in my opinio	n, death occurred a	t the time, date	and place, and	due to the cau	se(s) and manner stated.
o the vithin	о тие ющрік	Σ	only one) 3 L Certifying Nurse  29b. Signature and title of certifier	Practioner: To the best of my kno	wiedge, deat	29c. License		ce, and due to tr	29d. Date sig		
F > 1	J		1 Jaginna	× -		AT 2	438941	,			
	<u></u>		30. Name and address of person who cor			)				- Ver	21218
	4		JULIET GYEBI-FO	3. Registrar's Signature	MEMOX	RIAL H	DSPITAL	BALTI	MORE	, MD	21218
В	Stat egistra		SEP 1 4 2010	3. Registrar's Signature	park	las		•		,	
100	-Sign c	al ·	API 7 27016	1							

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State of Maryland / Department of Health and Mental Hygiene

onn Randali Ye		S(a 1- For State Registrar	te of Maryland		ificate of Dea		eniai my		g. No.	10 2876
Physicia Medical Exami	an/	Decedent's Name (First, Middle,     John Randa11						2. Date of Deat Month August 18		3. Time of Death 1612 hrs
/		4a. Facility Name (if not institution				, Town, or Location	on of Death	August 10	4c. County of De	
		631 Aldershot Road  5. Social Security Number	3. Sex 7. Age	e (In yrs. las		imore	Inder 24Hrs.	8 Date of Birt	Baltimore C	County  Birthplace (State or Foreign
Funeral Director			1 XM 2 F	67			ours Min.	T .		Country) ennessee
th with the Maryland ems 23a nr 28a-f show any it be mutified at once.	Funeral Director	10a. State 10b. County MD Balti:  10e. Street and Number 631 Aldershot  11. Marital Status 1 Never Married 2 Mar	Road  12. Was Decedent	Ba	i. 13. Was Dece	Zip Code 21.2  dent of Hispanic ocity Cuban, Mexic		ecify Yes or No-	og. Citizen of What 0 USA 14. Race - A White, et	merican Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a nr 28a-f sh traumatic event, the Meckel Examiner must be mufifted at once	Completed by Fur		1 Yes 2 If Yes, Give Year or Dates:		16a. Decedent's Usu during most of v	vorking life. DO N	ive kind of w	red)	16b. Kind of Busine	nite sss/Industry unk
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	Be Co	17. Father's Name (First, Middle, L	·			18. <b>M</b> ot			Maiden Surname)	
212 Should be and Ments is mark		John Randall Y  19a Informant's Name/Relationsh  John Randall Y  John J. Yeage	n (Type Brint )			•		Rural Route Num	ber, City or Town, S	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Mediany or other traumatic event, the Mediany.		20a. Method of Disposition  1 Burial 2 Cremation  4 X Donation 5 Other Soc	3 Removal from Sta		2887 Swalace of Disposition (Nematory or other pla	lame of cemetery		<u> Lawren</u> Date	ceville 20c. Location - Ĉit	
Balti permit. Departm Imports injury o		21. Signature of Funeral Service L	icensee	ector	State	nd Address of Face Anatomy more, MI	v Boar	d 655 W	. Baltimo	ore Street
Physician /Medical Examiner		23a. Part. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	n each line. a. Atherosclerptic	Cardiova	Do not enter the mod scular Disease	le of dying, such a	as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital nr Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkr	4 Pregnant at	, ,	2 Fetal dea		topic pregna	ncy	23d. Date of del Month	ivery Day Year
F. P.O. E ires that the d signed by the	ā	Part II. Other significant condition	ons contributing to deat	h but not re	sulting in the underly	ing cause given ir	n Part I.			e to the cause of death?  Probably 4  Unknown
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Division To the Hospital nr Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:		not be	njury - At ho	me, farm, street, fact	ory, office building	g, etc.	28f. Location (\$ or Town, \$		r Rural Route Number, City
Di To the Hospital 1 within 24 hours a To the Funeral I completely filled	Medical C		ysician: To the best of m							
To:	Med	29b. Signature and title of certifier	and manner stated.		4	29c. License num O.C.M.E.	ber	1	29d. Date signed September 3,	(Month, Day, Year) 2010
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COME

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar Jack Titus MD.

31. Date filed (Month, Day, Year)

Deputy Chief Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SHARON ZERVITZ 2010 12:04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL N/A BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Country) 1 M 2 F 01/16/1943 67 Director 215-42-6537 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o Funeral 6235 BLACKSTONE AVENUE 21209 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. Specify: WHITE "natural", 3 Divorced 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ LEVIN permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic MAURICE SONIA FINKELSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMUEL ZERVITZ/HUSBAND 6235 BLACKSTONE AVENUE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) TIFERETH ISRAEL CEM. 09/07/2010 BALTIMORE, MD 21. Signature of Funeral Sen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MUO Cardia disease or condition Medical resulting in death) Due to ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Drabetes melle and burial-trar Due to (or as a consequence of) attending physician Physician/Medical morbid Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown page 2 should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 100 မ 1 Inpatient 2 TR/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation **Director:** Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 251426 Se 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 31. Date filed (Month, Day, Year) Registrar's Signature State

J DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 850 Medical 4a. Facility Name (if not institution, give street and number, PRINCE GEORGE'S Town, or Location of Death **Examiner** CAPITOL HEIGHTS CONSTANT CARE ASSIT. LIVING FAC. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

JULY 3 1944 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2 X F CONNECTICUT Director 66 046-36-4703 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. See 15 is marked other than "natural", or items 23a or 28a-f sho ther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGE'S CAPITOL HEIGHTS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 USA 1213 DOEWOOD LANE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc Completed by 1 Never Married 2 Married Yes : Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PROGRAM ADMINISTRATOR PRIVATE 4+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည THOMPSON LUVENIA FRED THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13006 SALFORD TERRACE UPPER MARLBORO, MARYLAND 20772 ALIS ADJAHOE/DAUGHTER item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. Date Burial 2 Cremation 3 Removal from State CEDAR HILL CEMETERY 8/27/2010 SUITLAND, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licen-22. Name and Address of Facility 7474 Landover Road Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on the line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ Pla. disease or condition resulting in death) Medical Due to (or as a nsequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events death certificate be execu resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 2 🖾 No 1 Tyes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: 2 **N**o 4 Nursing Home 5 Residence 6 ther (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 5 Pending 2  $\square$  No Investigation within 24 hours filer deat To the Funeral Director 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1005 AM 2010 G. Anastasi 1CIUS Maria Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F July 28, 1928 82 Washington, D.C. Director Yrs. 578-30-5120 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any higuy or other traumatic ev onthe trained in any higuy or other traumatic event, the Medical Examiner must be notifiled at 10b. County 10c. City, Town or Location 10d. Inside City Limits West Director 1 🗌 Yes 2 🛭 No Virginia Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35 Gideon Lane 25419 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Aluminum Manufacturer Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosario Anastasi Angelina DeLeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Minor - Daughter 35 Gideon Lane Falling Waters, West Virginia 25419 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cem. Sept.3,2010 Brentwood, Maryland 4 Donation 5 XOther (Specify) Entombment Ignature of Ineral Osborne Adunerally Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury PERFORMON physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 the attending phone of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the tra IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 I Inknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 ည 1 Depatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work' 2 Accident 1 Tyes 2 🗆 No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar To the best of my knowledge, death commence the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signatu

e and title of certifler

SEP 01

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Ren 1. AM cility Name (if not institution, give street and number) 4c. County of Death Examiner House NOW 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min Month, Day, -38-799 Director Washington, DC Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State the Medical Examiner must be notified at 10d. Inside City Limits rector Prince George's College Park Md 1 X Yes 2 No ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20740 10107 Baltimore Avenue # 4110 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐XNo Specify: 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant; If item 27 is marked other than in Elementary/Seconday (0-12) College (1-4 or 5+) Private Dishwasher Department of Health and Mental Hyg Important: If item 27 is marked othe an injury or other traumatic event, in ince. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Ellis Walter G. Brew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740 5104 Iroquois Street College Park, Maryland Thomas Brew/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 9/9/2010 Brentwood, Maryland Signature of Funeral Service Lic 22. Name and Address of Facility J. B. Jenkins Funeral Home Landover Road Landover, Maryland 20785 23a. Part 1. Enter the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, list only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Hypertensive Medical resulting in death) Due to (or as a consequence of) Examiner End Stage Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of certificate 1 ☐ Yes 2 😾 No Yes 2 x No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Tother (Specify) Casev House 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29c. License number AUGUST 27, 2010 D606 34 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1160 VARNUM STREET # 021 N.E. WASHINGTON, DC 20017 BINDU JOSEPH 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

SEP 0 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland State of Maryland		irtment of F t <i>ificate of L</i>			ene2010	28768
	Physicia		Decedent's Name (First, Middle, Last)  Michael Blake				2. Date of Death August 2	25 <sup>Day</sup> 2010 ear	3. Time of Death 3:17 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)  Southern Maryland Hospital			Location of Death		4c. County of Dea	George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 577-60-7601	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) June 26,	9. Bi	rthplace (State or Foreign DC
	>	L	Usual Residence of Decedent	y, Town or Loc	eation		Julie 20,	1940	10d. Inside City Limits
	Marylan 28a-f sh etified a	Funeral Director	Maryland Prince George's	, 10WH OF 200		istrict H	Heights		1 ★ Yes 2 □ No
	ith the l 23a or 2 at be no	ral Di	10e. Street and Number		10f. Zip Code	20747	10	ng. Citizen of What C United	
	leath w items ? er mus	Fune	7420 Marlboro Pike  11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?	3. 13. W	/as Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	14. Race - Am	erican Indian,
030	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates.		☐ Yes 2 🗷 No		Thous, otoly	Black, Whi Specify: B1	· ·
9500-612	72 hour n "natu fedical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done of NOT use retired)	ation luring most of worki	ing 1	6b. Kind of Business	Industry
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Maryland	be filed ental H rked otl ic even	To Be	17. Father's Name (First, Middle, Last)  Joseph Blake			18. Mother's Name	e (First, Middle, Ma Sprige	·	
Mary	should h and M 7 is ma traumat		19a. Informant's Name/Relationship (Type, Print)	1			l Route Number, C	City or Town, State, Z	
re, r	permit. Page 1 and 2 should be filed wit popartment of health and Mental Hygie Important If item 27 is marked other any injury or other traumatic event, tt once.		Rhonda Stuckey/ Daughter  20a. Method of Disposition 1  Burial 2 🖾 Cremation 3  Removal from State	Place of Dispos	sition (Name of patory or other place	ew Drive		.11, Mary1 Oc. Location - City o	
saitimore,	iit. Page irtment irtant: I injury ol		I Duliai 2 Ef Ciellation 3 E hemovaliton otate	Lee's C	rematory Name and Addres	9/4/	2010		Maryland
g	permit Depar Impor any in	y y	21. Signature of Funera Service Licensee	I MA				neral Hom .ngton, DC	•
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5	s that th gned by oe detac	by Ph	Part II. Other significant conditions contributing to death but not residual.	ulting in the ur	nderlying cause giv	en in Part I.			o the cause of death?
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Lec Lec	The law ate has page 2	Completed	144/1010 30 31 31				autopsy perform 1 🗌 Yes 2		completion of cause of
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0	ing Phy (fter this uneral d	ate: To	1 Companion 2 Co	28b. Time of injury	28c. Injury work	rat ?	28d. Describe how	ce 6 Other (Spe	GIIY)
DIVISION	Attender deathector: Actor: Ac	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,	me, farm, stre		Yes 2 □ No		eet and Number or R	ural Route Number,
2	pital or ours aft eral Dir filled in	100	29a. Certifier 1 Certifying Physician: To the best of my knowle		ccured at the time	date and place, an	City or Town,		rated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending the completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2   Medical Examiner: On the basis of examination only one) 3   General Structures of the basis of examination only one) 3   General Structures of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination only one of the basis of examination of the basis of examination of the basis of examination of the basis of examination on the basis of examination of the basis of examination of the basis of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of examination of examination of the basis of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examinat	n and/or investi	gation, in my opinic eath occurred at the	n, death occurred at e time, date and plac	the time, date and e, and due to the c	place, and due to the ause(s) and manner a	cause(s) and manner stated. s stated.
	<b>2</b> ₩ <b>2</b>		29b. Signature and Interesting Programme (1996)		29c. License		29	d. Date signed (Mon	2010
2			30. Name and address of fers in who completed cause of death (Item Ki haw I 328 S	23a) (Type, Pr	rint)	166 56	Purte 310	bach	instande zunza
	Stat	te	31. Date filed (Month, Day, Year) 32. Registry's Sign	resta		in al		VV	1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19 ay 2010 18:08 M SHIRLEY August NICOLE BEANER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CENTER CLINTON Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Min. Hours 8767 1973 Washington, DC 579-90-7679 Director 37 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 □ No DCWashington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3371 23rd Street SE # 302 20020 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. <u>۾</u> 1 XNever Married 2 Married 1 ☐ Yes 2 🗵 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 11 Disabled Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry E. Beaner Shirley R. Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Quenton Beaner / Son 3371 23rd Street SE # 302 Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 😾 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 8/26/2010 | Alexandria, VA 21. Signature of Funeral Service icensee 22. Name and Address of Facility Alexander S. Pope Funeral Home M01085 2617 Penn. Ave. SE Washington, DC 20020 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 - Fetal death in the past 12 months? Year Pregnant at time of death Month Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACQUIRED IMMUNE DEFICIENCY 1 Yes 2 No 3 Probably 4 Unknown COLITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this completed filled in by the funeral 27. Mann of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. ☐ Accident ☐ Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) D0064986 8/23/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Regiștrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Sig

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	Physicia	n/	Decedent's Name (First, Middle, Last								2. Date of I Month		Day	Year	3. Time of Death
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	Examin	69 W. Green St. Westminster												rroll	
	Funeral	5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.												g. Birt	hplace (State or Foreign intry)
_	Director		218-24-4089 80 Yrs. Wall Residence of Decedent								(Month, l		930_	MD	,
	and show lat	ō	10a. State 10b. County		10c. City,	Town or Lo	cation								10d. Inside City Limits
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Division of Vital Records,	l or Attenc after death Director: /	Certificate:	4 Homicide determined	28e. Place of Inju- building, etc		ne, farm, str	eet, facto	ry, office			28f. Location City or 7			ber or Rui	ral Route Number,
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	To the Hospital or within 24 hours after To the Funeral Direction completed filled in the funeral or the funeral Direction for the funeral filled in the funeral funeral filled in the funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral	Meo	only one) 3 Certifying Nurs				death occ	urred at the	e time, date						cause(s) and manner stated stated.
			29b. Signature and title of certifier				29	c. License			,		7	i	ı, Day, Year)
	230		30. Name and address of person who co	- MD	eath (Item /	23a) /Tune =	Prin+\	1/S	10)8	(5)			8/2	20/10	2
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		e	31. Date filed (Month, Day, Year)	32. Registra		re									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joseph Robert Bolesta, Jr. Physician/ August 20 TO 19<sup>ay</sup> 4:12 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster 724 Glen Dr. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jan 11, 1941 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 218-36-6612 1 ☑ M 2 □ F <sup>c</sup>Maryland **Director** 69 Usual Residence of Decedent 28a-f shov 10b. County 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified Westminster Carroll Maryland 1 Yes 2 X No 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21157 724 Glen Dr. ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 🔀 Married ģ 1 ☑ Yes 2 ☐ No If Yes, Give 1960 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) City Police Police Officer <u>2 years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Delores Plate Joseph Robert Bolesta, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Bolesta/Wife item 27 724 Glen Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 08/25/10 Woodbine, MD 21. Signature of Funeral Service License 22. Priets Fineral Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Opset and Death Physician/ accinoma 1220 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, 1 ☐ Yes 2 ☐ No 3 🗙 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 🗌 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 XNaturai 5 Pending Division Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death red at the time, date and place, and due to the cause(s) and manner as stated. Chrill Kdin Miles. License number 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D0061040 trofersor of O. John Hopkins Hospita of person who completed cause of death (Item 23a) (Type, Print) MOPLD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 23 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3:25 PM indle R 0++ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mospital Hagerstown ashin Shinpto. 0 ptroa If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral XX**M 2 □ F Days Hours Min. May 6,1948 Maryland Director 62 9-52-1694 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Hagerstown Marvland Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 USA 10801 Hartle Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1966If Yes, Give Black, White, etc. 1 ☐ Never Married 2 🔀 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced Specify: Completed 1972 White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Officer Prison Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Betty Agnes Bowman Richardson Banzhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10801 Hartle Drive Hagerstown, Maryland Debi Banzhoff-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sept.3,2010 Williamsport, Maryland Greenlawn Mem. Park ture of Juneral Servi Osborne Funeral Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ 2 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No g Unknown g Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has, page 2 autopsy performed? Yes 2 2 No this certificate 1 Yes 2 No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) æ Hospital 1 ☐ Yes 2 No <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred After Natural injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier orla 2010

3H-7+1

Registrar

HOSPITEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bey

ene

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vierling Burriss 2010 Jean August 18:40P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 - M 2 1 (Month, Day, ar. 18 Washington,D.C 216-22-0781 83 Director Mar. Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Md. Montgomery Silver Spring 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11908 Ivanhoe Street 20902 United States or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify. If Yes, Give White "natural" 3 🗷 Widowed 4 🗆 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment, Important: If item 27 is marked any injury or con-2 Robert Vierling Elizabeth W. Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn F. Burriss / Son 8700 Links Bridge Lane, Thurmont, Md. 21788 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. 9/2/10 Alexandria, Virginia 21. Signature of Fun all Service Ucens Name and Address of Facility
Muriel H. Barber Funeral Home 1402 Box 5038, Laytonsville. 0. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Unknown ed by the a 2 No g 🗌 Unknown signed b Part II. Other significant conditions contributing to death 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy death? is certificate h 1 Yes 2 No Yes 2 Be 25. Was case referred 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 은 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge th occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tale of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

1.5

's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral	٦	5. Social Security Number 6.	Sex	7. Ag		ast birthday)	If Under 1 Year Months Days	r If Unc	der 24 Hrs.	8. Date of Bir	th v. Year	9		State or Foreign
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permit. Departr Imports any inju		21. Signature of Funeral Service Licer	"h//	nu	usel	$\sim V_{a}$	. Name and Addr L5 E. Wi			NNICH I				40
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DHMH 17 Rev 7/2009

Physician/

Medical

Director

Funeral

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Examiner

Funeral

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney | | | 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8/25/2010 Physician/ Loreda Belle Carr 10:30am Medical 4c. County of Death
Caroline 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Denton Caroline Nursing Home 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 □ M 2XXF Months Hours Min. 235-44-7287 Yrs. Director 78 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10b County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2xxNo MD Caroline Marydel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21649 USA 17949 Marvel Rd. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes XX No Specify: "natural", 3 Widowed AND Divorced Year or Dates th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important. If tem 27 is marked other t any injury or other traumait. 9 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Johnny Carr Ruby Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Frankford, DE <u>Mona Higgins</u> <u>34517 Virginia Drive</u> 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 8/30/2010 Hillcrest Cemetery Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, 21. Signature of Fundal Service License Dal 851 Annapolis RD. Gambrills, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebro Vascular Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 5 Pending 1 Anatural 1 🗆 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25 10 Do047534

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month)

Denton, MD 21629

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

920 Market St.

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 4:45 PM Physician/ Ella Louise Cook ugust Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Sunrise Assistant Living Severna Park If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 5/13/1921 5. Social Security Number Age (In yrs. last birthday) Funeral 1 ☐ M 2 XX Hours 446-14-8227 OK Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes X No Severna Park Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21146 USA 43 W. McKinsey Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) Yes 2 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: 3 xVidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Snow John Hyde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 215 Mill Harbor Dr. Arnold, MD 21012-1033 Frances Boyce Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If its
any injury or of ŏ 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/30/2010 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Septina Licensee 22. Name and Address of Facility Hardesty, Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 Vo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No GENERAL DEBILITY 24a. Was an autopsy Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be funeral director ASSISTED LIVIN Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: work? 1 ☐ Yes 2 ☐ No 1 🔁 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57531 ust 25 2010 MSneg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterang Havy millesville, mo mohit Nugi State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 - For State Registrar Ce	rtificate of Death	Reg. No.	010 28778
Physician	1. Decedent's Name (First, Middle, Last)  KEITH DANIELS		2. Date of Death Day AUGUST 26	3. Time of Death 2010 2:23 A M
/Medical Examiner	4- F. W. M. (M. 12- M.	4b. City, Town, or Location of Death	4c.	County of Death  INCE GEORGE S
Funeral Director	5. Social Security Number  579-19-7140  6. Sex 1 ★ M 2 □ F  7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)  GUYANA
vith the Maryland to 28a-f show be notified at Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li  MD PRINCE GEORGE'S LANHAM	ocation		10d. Inside City Limits 1 □ Yes 2 □ No
h with th 23a or 28 18t be no	10e. Street and Number 4207 KINMOUNT ROAD	10f. Zip Code <b>20706</b>	10g. Citiz USA	zen of What Country?
be filed within 72 hours after death with the Maryland that Hyglene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Exarity must be nothed at Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
ed within 72 houygiene. ygiene "natura" t, the Medical Et, the Medical Et	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12TH  16a. Deceding (Give life.)  Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) CCHANIC	king	nd of Business/Industry  PRIVATE
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to, wan yian the and 2 should be the ath and Mental tem 27 is marked other traumatic ev	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Ru	ral Route Number, City or	
) ë ° = 5	20a. Method of Disposition 1	KINMOUNT ROAD LAN sistion (Name of matory or other place)  CTION CEMETERY 9/1	Date 20c. Loc	ND 20706 cation - City or Town, State NTON, MARYLND
permit. Pag De artment Important: any injary o	21. Stockture of Europeal Service Linensee	2. Name and Address of Facility J.	B. JENKINS	FUNERAL HOME
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nysiciar nis certifi director	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No	Othor	th (Check only one) ome 5  Residence 6	Other (Specify)
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.  Medical Certification: To Be Com	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury 28f. Location (Street and City or Town, State)	occurred  Number or Rural Route Number,
the Hospital in 24 hours the Funeral opletely filled	29a. Certifier (Check only one)  1 **X Certifying Physician: To the best of my knowledge, deat 2 ** Medical Examiner: On the basis of examination and/or in and manner stated.			
To the within To the comple	29b. Signature and title of certifier	29c. License number D63688	29d. Date	e signed (Month, Day, Year)
6	30. Name and address of person who completed cause of death (Item 23a) (Type, GRIFFIN DAVIS M.D. 3001 HOSPITAL I	Print)	RYLAND 20785	5
State	31. Date filed (Month Dev. Year) 32 degistration			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Mary Catherine Dean 10:35 Medical Ana. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll <u> Lorien Taneytown Nursing Facility</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 F Hours Director 220-14-9259 Sept 1925 MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No MD Carroll Taneytown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Antrim Blvd. 21787 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Retai] Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Lawrence Ruff, Sr. Mary Catherine Conway t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Valley Meadow Cr., Apt. Al, Reisterstown, MD 21116 <u> Pauline Riggins - Daughter</u> other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/30/2010 Cremation Hampstead, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA Washington Rd. .Westminster. MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinatory arrespiratory arrespi Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions, Due to (or as a consequence or): If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 Yes 2 ed by the a P.O. I Part II. **Other significant conditions** contributing to death but not rejulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy or Attending Physician; The No Yes 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other 1 Tyes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier NJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 EWSIER 31. Date filed (Month, Day, Year) State AUG 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygien ? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August John David Dudderar 2010 10:25 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Golden Living Center Westminster 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, 218-32-3354 1 X M 2 🗆 F Months Days Hours Min. Mary land Director 74 1935 Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified Westminster 28a-f Maryland Carroll 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be Funeral 21157 715 Glen Drive USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1955ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white 1957 "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working City of life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Westminster Zoning Clerk 12 of Health and Mental Hygi item 27 is marked othe other traumatic event, i Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Danner Benjamin Ecker Dudderar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Glen Drive, Westminster, MD 21157 Shirley Dudderar, wife 20a. Method of Disposition 20b. Place of Disposition (Name of Schoolstern), crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō Department or Important: If any injury or once, 8/24/2010 Winfield, MD Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes each line. Approximate Interval Between Onest and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only g WSL 5+IVA 30. Name State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #±0 State of Maryfard Department of Health and Mental Hygiene 1 - State Amended #27, 28b, 28c, 28d, 28f Registrar & 2 per phys. WSH CCHD Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Month Physician/ Marian Virginia DeRosa 16:44 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL Br Itimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗙 F July 4, Year) 921 New York 104-18-5272 89 Director Usual Residence of Decedent 10b. County 10a. State **Florida** 10d, Inside City Limits permit. Page 1 and 2 should re filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is mar ed other than "natural", or items 23a or 28a-f sho any injury or other traumatin event, the Medical Examiner must be notified at 10c. City, Town or Location Completed by Funeral Director Broward 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3111 N. Ocean Drive USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Specify: white 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Electronics Bookkeeper 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Cafiero Michael J. Cafiero, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11748 Fitchwood Circle, Jacksonville, FL 32258 19a. Informant's Name/Relationship (Type, Print) Richard Mauro, grandson 20b. Place of Disposition (Name of MOUNT CreStopy or other place)
Mary's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 8/23/2010 Emmitsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 21. Signature of Funeral Service Licensee 22. Name and Address of Facility  $\prec$ 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) CERTIFICATION IN PROPERTY MEDICAL EXAMINER or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown is certificate has been signed by a director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Brain 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Subdural hematoma. 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 XInpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death,

To the Funeral Director: After this of completed filled in by the funeral directors. After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how Injury occurred Certificate: Natural injury 11:20A M 5 Pending 1 ☐ Yes 2 🗓 No Struck by vehicle August 8,2010 Investigation 6 Could not be x Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) North Seton And DePaul St, Emmitsburg, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Street Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kedetta Morr D0070852 HUXUST 18; 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Ave Baltimore Rodetta MORRIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 4 2010 Parks Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month 440 AM Mirian G. Dunn 08 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8 Date of Birth g. Birthplace (State or Foreign **Funeral** Months 1 M 2 XF NewYork 1112411921 121-12-1886 Director 88 Usual Residence of Decedent , or items 23a or 28a-f show iminer must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any nigury or other traumatic event, the Medical Examiner must be notified at one. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Fruitland Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA **2**1826 Bohnak Trailer Park, Lot 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. þ ☐ Yes 2 🗶 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Specify. Specify: 3 → Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Food Service 12 Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyna Roberts ပ Carl O'Leva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Cottontail Drive, Salisbury, Maryland 21804 Virginia Vitello daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Date cemetery, crematory or other place) □ Burial 2 XCremation 3 □ Removal from State Salisbury,Maryland Salisbury Crematory 8 27 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Home P.A. HOIIoway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final EMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Į Month Year Day 2 🗌 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by upleted filled in by the funeral director, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 Yes 2 No Yes 2 No Be 25 Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) after death. 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 24 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the vithin 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0051359 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. DIVISION ST,

State Registrar 31. Date filed (Mo

larion

Registrar's Signatur

amended 9-7-2010/wchd/map/item #10E Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#19b Per FH G907 9/27/10 JH
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Christine Alberta Boone Deal 30 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death County of Death foninsula Regional Medical WICOMICO If Under 8. Date of Birth Dec. 12, 1941 ocial Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕏 F Months Days Hours Min. 244-62-5149 North Carolina 68 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10h County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Wicomico Hebron 10e7Sy ee Land Numbe 5 10f. Zip Code 10g, Citizen of What Country? 23a Funeral <del>7304-</del>Levin Dashiell Road 21830 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give 0 þ 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Transportation Office Manager Shore-Up, Inc other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Harold Boone Rosa Elev permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 1917 1921 Ag Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7304 Levin Dashiell Road-Hebron, MD 21830 Charles Virgil Deal/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Springhill Memory Gardens 109/01/2010 Hebron, Maryland ture of Funeral Service Licensee 22. Name and Address of Facility Salisbury, Maryland Sign any Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause disease. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Retween Immediate Cause (Final Onset and Death Metastatic Physician/ Carcinona disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year 1 ∐ Yes 2 2 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate has , page 2 2 🗆 No 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work?
1 Yes 2 No 5 Pending after death. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the F only one 29b. Signature and title of certifier 29c. License number M,0 art 030690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25,0 501:660 MA M.0 100 31. Date filed (Month, Day, Ye 32. Registrar's Signatu State Registrar

sail.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ TEVEN FLURY 20/0 DOW Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 606A Overhill Drive Edgewater Anne Arundel 5. Social Security Number 214-46-7069 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours 02/10/8/11/948 Wasmington, D.C. Director Usual Residence of Decedent 10a State with the Maryland 10b County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Marvland Anne Arundel Edgewater 1 Yes 2 X No 0 10e, Street and Number 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be r 10g. Citizen of What Country? Funeral 606A Overhill Drive 21037 United States filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 0wner Landscaping permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Parsons Flury Betty Jane Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606A Overhill Drive, Edgewater, Maryland 21037 A. Dianne Flury/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 08/26/2010 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AROND Physician/ 61 disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any hading cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Directo (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed and -tran nding physician ar use as the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξ in the past 12 months? Pregnant at time of death 5 Other (specify) Month signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy performed? certificate Yes 2 No completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2/No Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1. Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 Accident 3 Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 0 12

State Registrar 31. Date filed (Month

741

istrar's Signature

DEFENSE HEHWAM

Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death AUGUST 25 Day 2010 Year MILDRED B. GREEN 11:55AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8501 SUMTER LANE CLINTON PRINCE GEORGE'S 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days 1 M 2 X F Months Hours (Month, Day, Year 2/4/1916 Washington, <u>577-70-3035</u> 94 DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8501 Sumter Lane 20735 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify Black 3 😾 Widowed 4 🗆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Charles Duckette Harriet Duckett Gauntt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Cain / Daughter Sumter Lane Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial 9/3/2010 Landover, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Pope Funeral Homes, P.A. MOLOS 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 7. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): HYPERLIPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) HYPERTENSION resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 XNo 9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy

Physician/ Medical Examiner

Physician/

**Funeral** 

Director

or 28a-f show

Directo

Funeral

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Completed

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2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

l and 2 should b ! Health and Mei tem 27 is mark

permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr

Baltimore, Maryland 21215-0036

Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran the certificate has been signed by rector, page 2 should be detach

Box 68760

P.0.

Division of Vital Records,

Examine Physician/Medical þ Completed Be ျ

24b. Were autopsy findings available prior to completion of cause of death? performed' 1 Yes 2 K No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Hospital: 2 😾 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔽 Natural 5 Pending Accident 1 \( \text{Yes} \) 2 🗆 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practiones: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sia ture and title of ca 29c. License numbe 29d. Date signed (Month, Day, Year)

D58177

Brandywine, Maryland 20603

State Registrar

31. Date filed (Month, Day, Year) SEP 0 1 2010

30. Name and address of person v

Samuel Cross

e of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jerome Edward Hawkins, Sr. August 2010 4:35 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 9. Birthplace (State or Foreign Country) Wash., D.C. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 03/18/1944 1X M 2 **Director** 578-58-0466 Yrs. 66 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director D.C. 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 635 49th St., N.E. 20019 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Maintenance Worker National Park Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Unknown Lucille Ann Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome E. Hawkins, Jr. / Son 635 49th St., N.E., Washington, D.C. 20019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory, Inc. 09/09/10 Beltsville.Md 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licensee aug 4925 Burroughs Ave N.E. Washington, D.C. 20019 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Multiple Myeloma
Due to (or as a consequence of): vears ) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 2 No ed by the a detached f g 🗌 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has i irector, page 2 s autopsy 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: မ 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Matilda H. So, M.D. 1221 Mercantile Lane, Largo, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

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Matildat

D56520

29d. Date signed (Month, Day, Year)

20774

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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-	Funeral	-	Ft. Washington  5. Social Security Number		n yrs. last birtho	fav)	Ft. Was	shington If Under 24 Hrs.	8. Date of Birth			orge's
	Director		363-22-9438	1 □ M 2 🔼 F	86 Yı		Months Days	Hours Min.	(Month, Day, 06/21/	Year) 1924	Cou Mi	nplace (State or Foreign ntry) Chigan
	and show lat	or	Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town o	r Loc	ation				T	10d. Inside City Limits
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	death v items ner mu	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent Eve	r in U.S.	13. W	as Decedent of His Yes, specify Cubar		ecify Yes or No-	14.	Race - Ameri	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 ☐ Never Married 2 🗷 Marrie 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No	1945- 1946		Yes 2xXNo		nicari, etc.)	Spe	3lack, White, c <i>ify:</i> <b>W</b> }	, etc. nite
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aryla	ould bund bund Men marke matic	_	William L.  19a. Informant's Name/Relationship	Ward	10h N	Anilina	Address (Street a	Mar		Davis	- 04-4- 7/-	0-4-)
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8760	tificate ng phys as the		IF FEMALE:	<b>d</b>								
89 X	ath cert attendir for use	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death		Ectopic pregnancy Other (specify)	,			Date of delive	very Day Year
Division of Vital Records, P.O. Box	the de	hysi	1 ☐ Yes 2 <b>X X</b> No 9 ☐ Unknown	9 🗌 Unknown								
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	Hospit 24 hour Funera	Medical	(Check 2 L Medical Exa	hysician: To the best of my aminer: On the basis of exam	nination and/or ir	ivestig	ation, in my opinion	<ul> <li>death occurred at</li> </ul>	the time, date and	l place, and	due to the ca	use(s) and manner stated.
	To the within 2 To the Comple	Ž	only one) 3 L Certifying N 29b. Signature and title of certifier	lurse Practioner: To the bes	t of my knowled	ge, de	ath occurred at the 29c. License				manner as st	
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_	12		30. Name and address of person wh	Kleiman MD			vingston	Rd. Ft	Washing	lon P	/D 20	744
	Stat Registra	е	SEP 0 1 2010	Agent 32. Register's	signatur	<b>J</b>					20	, 17
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25ay August 2010 11:10 PM William John Hallahan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4427 Windsor Farm Road Harwood Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 11 M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 0*11/1057*4917 New York 128-10-2597 93 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Anne Arundel Harwood Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral United States 20776 4427 Windsor Farm Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Financial Consultant Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James P. Hallahan Mary Casey 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4427 Windsor Farm Road, Harwood, Maryland 20776 Mary Kathleen H. Smith/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 09/23/2010 Arlington, Virginia 5 Other (Specify) 4 Donation Signature of Fur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final congestive Heart Physician/ disease or condition Jeans Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hospital or Attending Physician: The law requires 124 hours after death. 1 Yes 2 No 3 Probably 4 tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 this certificate 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 400 Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 26,2010 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holidan Malta 132 3. MO 32. Resistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

**Division of Vital** 

10-06430 Brenda Jeanette Je	Please Type or Print in Black Indelible State of Maryland / Department	•	
	1- For State Certificate (	of Death	Reg. No. 2010 2878
Physician Medical Examine	BRENDA JEANETTE JOHNSON	2. Date of De Month August 2	5, 2010 Year 2131 hrs
	Facility Name (if not institution, give street and number)     Prince Georges Hospital Center	4b. City, Town, or Location of Death  Cheverly	4c. County of Death Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217-84-0477 1 M 2 KF 49	If Under 1 Year If Under 24Hrs. 8. Date of B Months Days Hours Min. MAY 2	inth(MM/DD/YYYY) 9. Birthplace (State of ForeignWASHINGTON Country) DC
any	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Loc	ation	10d. Inside City Limits
fand fand sonce	MD PRINCE GEORGE"S UPPER MAI		1 X Yes 2 No
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	75 CABLE HOLLOW WAY	10f. Zip Code 20774	10g. Citizen of What Country? USA
Leath with the ritems 23a tust be not uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	L Vas Decedent of Hispanic Origin? (Specify Yes or N f Yes, specity Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
fer dear	1   Yes 2   No   3   Widowed 4   Divorced If Yes, Give Year   1	Yes 2 X No specify:	Specify: BLACK
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2121 ould be fil d Mental B s marked fic event,		ing Address (Street and Number or Rural Route Nu	
, MD and 2 sho ealth and em 27 is rraumati		CABLE HOLLOW WAY UPPER In osition (Name of cemetery, Date	IARLBORO, MARYLAND 20774  120c. Location - City or Town, State
Baltimore, oemit. Pages I an Department of Hea Important: If ites injury or other tr	1 X Burial 2 Cremation 3 Removal from State crematory or o	other place)	LANDOVER, MARYLAND
Saltin epartme nportar	21 gnature of Funer Service Lisee 22.	Name and Address of Facility J. B. JEN	NKINS FUNERAL HOME
Physician	23a. Part I. Enter the disease or complications the cause I the death. Do not enter	7474 LANDOVER ROAD LANDO	
/Medical Examiner		liovascular Disease	Between Onset and Death
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  b.		
iner	if any, leading to immediate Due to (or as a consequence of); cause. Enter Underlying Cause		
led nisit Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
e executed cian and rial - transit dical Ex	x unpended 23a,27 per m	ne g907 9-16-10 vt	
x 68760, n certificate be e ending physicia use as the burial ician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
Box 68760, s death certificate be exe the attending physician and for use as the burial hysician/Medics	past 12 months?	Other (Specify)	
P.O. Box that the death ned by the atte detached for v	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did I	obacco use contribute to the cause of death?
- s s s -		1Ye	an 24b. Were autopsy findings available
of Vital Records, in Physician: The law required ther this certificate has been signeral director, page 2 should be not To Be Completed in: To Be Completed		auto	psy prior to completion of cause of death?
Vital Reysician: The his certificat director, page Co	25. Was case referred to medical	26.Place of Death (Check only one)	2 No 1 Yes 2 No
of Viting Physici ing Physici After this c	examiner? 1 V Yes 2 No  1 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		Residence 6 Other:
Division of Napial or Attending Ph. rours after death. reral Director: After tiffilled in by the funeral Certification: T	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No	
Division spinal or Attendin hours after death. Innersal Director: <sup>A</sup> y filled in by the fu Certification	3 Suicide 6 Could not be determined	eet, factory, office building, etc. 28f. Location ( or Town, 5	Street and Number or Rural Route Number, City State)
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occur		
To the Howithin 24 To the Figoraphetel	one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.  29b. Signature and title of certifier	ation, in my opinion, death occurred at the time, date  29c. License number	and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	in hi, vo	O.C.M.E.	August 26, 2010
	30. Name and address of person who completed cause of death (Item 23a)	not Raltimore MD 21201	
State	Ling Li, MD Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 21201	
Registra	DEP U 3 ZUIU CAMME P. 19000		

			For State	State of M	aryland / Dep			Mental Hy		00700
			Registrar  1. Decedent's Name (First, Middle, I	Loot	Ce	rtificate of L	Death		neg. New V	0 28790
	Physicia	ın/		,				Date of De     Month	Day Ye	3. Time of Death
	Medic Examin		CATHY  4a. Facility Name (if not institution, g	JACKSON		4b. City, Town, or	. I tion of Doot	AUGUST		
	) Examin	er	7804 Locris Dr.						4c. County of I	
	Funeral				e (In yrs. last birthday)		If Under 24 Hrs			Birthplace (State or Foreign
	Director	6	217-72-6682	1 □ M 2 🖾 F	52 Yrs.	Months Days	Hours Min.	Aug.	, Year) 958	Country) MD
	d iow	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	antine .				Transport of the second
	arylan a-f sh fied a	양	,	Cannon						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28g		MD Prince  10e. Street and Number	Georges	Upper Ma	10f. Zip Code			10g. Citizen of Wha	
	with th	eral	7804 Locris Dr.			20772	)		USA	it Country :
	eath v tems er mu	Funeral Director	11. Marital Status	12. Was Decedent 8	Ever in U.S. 13.	Was Decedent of Hi	ispanic Origin? (S	pecify Yes or No-		American Indian,
9	fter d , or i	P	1 Never Married 2 Marrie	d Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give	No	If Yes, specify Cuba  1 ☐ Yes 2 🖾 No		to Rican, etc.)		Vhite, etc.
Š	iurs a tural' al Exa	Completed	3 🖾 Widowed 4 🗌 Divorced	Year or Dates.		TLI Yes 2 110	Specify:		Specify:	Black
21215-0036	72 ho n "na ledio	nple	15. Decedent' (Specify only highest		(Give	dent's Usual Occupa	ation during most of wo	rking	16b. Kind of Busin	ess Industry
212	/ithin iene. r tha	Co	Elementary/Seconday (0-12) 12th	College (1-4 or 5	)+)	OO NOT use retired)			   Ritz Cam	era
ַס	iled wall Hyg othe	Be	17. Father's Name (First, Middle, Las	st)	Tech	Treatm	18. Mother's Na	me (First, Middle,	, Maiden Surname)	CIG
<u>Jar</u>	d be f denta arked rtic ev	욘	Harold Singfiel	.d			Hazel	Vera Lit	aker	
Maryland	2 should be filed within 72 hours after death with the Maryland th and Mental hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ng Address (Street a	and Number or Ru	ıral Route Numbe	er, City or Town, State	, Zip Code)
	1 and 2 of Health item 27 other tr		Dana Lynne Sing	field - Sis		East 83rd	1 St. #4	C New Y	York, NY	10028
Baltimore,	⊕		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3	☐ Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other plac	e)	Date	20c. Location - City	y or Town, State
	it. Page 1 rtment of rtant: If it njury or o		4 Donation 5 Other (Spe		Metropoli				Alexandri	
Ra	permit. Pag Department Important: any injury o		21. Signature of Fujleral Service Lice	RW ods	, Ma	<sup>2. Name and Addres TShall s 308 Suitla</sup>	Funeral and Rd.	Home of Suitlar	Maryland	746
ī			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	omplications that caused	the death. Do not en					Approximate Interval Between
~	Physician/		Immediate Cause (Final disease or condition	ath	msile	rutre C	erchio	VASCUL	les Di Se	Onset and eath
	Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	\$ 10				7-70-00
		e	Sequentially list conditions,	b. Due to for so	my as	an ce				Unknown
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	a con A uence of):	Trin	1			Call out
	xecut n and al-tra	Еха	that initiated events resulting in death) Last	C. Due to (or Va	onsequence of):					ariene v
3	cate be executed physician and s the burial-transit	dical		d						
00/00	tificate ng phy as th		IF FEMALE:							
	tendii r use	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3 [	Ectopic pregnanc	у		23d. Date of	
	e deat the at ned fo	ysic	1  Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death 5	Other (specify)			Month	Day Year
Š	at the		Part II. Other significant conditions	s contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
.C. BOX	es the signer	by								
5.	= 0	Ö						1 🗆	Yes 2 ☐ No 3 ☐	Probably 4  hknown
5.	requir been should	etec								
	he law requir te has been s age 2 should	ompleted		*****				24a. Was auto perfo	an 24b. Were prior prior deat	e autopsy findings available to completion of cause of h?
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State of Maryland / Department of Health and Mental Hygiene For State Registrar 28791 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Mary Christine Krug 26, 2010 0315 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**) F 76 May 22, 215-32-9354 1934 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other thaumatic event, the Modical Exc. in at matter or cultilised at any injury or other thaumatic event, the Modical Exc. in at matter or cultilised at 1 Yes 2 No Taneytown Director Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21787 USA 45 George Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Elizabeth Koontz John Samuel Stover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 George Street, Taneytown, MD 21787 Michael K. Stover, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donetion 5 □ Other (Specify) Trinity Lutheran Cem | 8/30/2010 Taneytown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 K ton Approximate Interval Between Onset and D 23a. Parl). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to ( as a consequence of) Examiner 1h Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-transit Due to (or as a consequence of) P.O. Box 68760 the attending physician Completed by Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy detached for Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, pe 1 ☐ Yes 2 1 No 3 Probably 4 Unknown director, page 2 should peen : 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 Yes 2 No certificate 2□ No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 3 □ DOA ٩ this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred s after death. 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24 1 To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number address of person completed cause of death (Item 23a) (Type, Print) Poole Rel, Westminster, MD 21157 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#23a per Phy State of Maryland / Department of Health and Mental Hygiene State Registrar 8/27/2010 AACO HEALTH DEPT CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Knower 07:56 AM tewar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arunde Medicul Center Anne tunapolis Avundel 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min (Month, Day, 76 Director 261-52-4340 June 03. 1934 Alabama Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 10 Constitution Avenue 21401 USA ral", or items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry DuBarry Knower Elizabeth Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Freeland/Wife 87 Stewart Drive #309 Edgewater, MD 21037 20a, Method of Disposition 20b. Place of Disposition (Name of Date 25. 20c. Location - City or Town, State cemetery, crematory or other place Aug. ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory, INC. Ž010 Baltimore, MD 21. Signature of Fiveral Service Lives 22. Name and Address of Facility **Cremation** Direct 495 Ritchie Hwy. <u>Severna Park</u> MD 21146 23a Fart 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Filysiciali disease or condition resulting in death) Ventricular Fibrillation Days Yéa Medical Due to (or as a consequence of): 'ēars Coronary Artery Examiner **⊷**Disease Esquertially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit the attending physician and the for use as the burial-transit TUNOT that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performs 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one, examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Pay Suite 500 Annapolis (MD 21401 Bead 2007 ANI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 7 2010

DHMH 17 Rev 7/2009

Registrar

		For State	State of Ma	-	partment of I		/lental Hy	giene		0.000
		Registrar  1. Decedent's Name (First, Middle, Las	t)		ertificate of I	Death	2. Date of Dea	Reg. No	10	28793 3. Time of Death
Physici		Norman Richard Ma	,				Month Aug. 21	Day	Year	8:42 A <sup>M</sup>
Med Exami		4a. Facility Name (if not institution, give	~		4b. City, Town, o	or Location of Death	mug z.i	•	y of Death	1 0:42 A
- A		103 E. Green St.			Westmir			Carro		
Funera Director		5. Social Security Number 6. Se	X M 2 □ F 7. Age	e (In yrs. last birthda 80 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	Cour	place (State or Foreign htry)
3	1	215-26-8922 Usual Residence of Decedent		- 80			May 13,	1930	L MD	
yland -f sho ed at	cţo	10a. State 10b. County		10c. City, Town or					1	10d. Inside City Limits
e Mar r 28a notifi	ğ	MD Carroll  10e. Street and Number		Westmin	ster 10f. Zip Code					1 ☐XYes 2 ☐ No
vith th 23a o st be	ra				21157			10g. Citizen of	What Cou	ntry?
eath v tems er mu	Funeral Director	103 E. Green St.  11. Marital Status	12. Was Decedent E	ver in U.S. 1	3. Was Decedent of F	lispanic Origin? (Spe	cify Yes or No-	U.S.A. 14. Ra	ce - Americ	can Indian,
5-UU36  2 hours after death with the Maryland "natural", or items 23a or 28a-f show cdical Examiner must be notified at	à	1 X Never Married 2 Married	Armed Forces?  1 X Yes 2 If Yes, Give		1 Yes 2 Wo	an, Mexican, Puerto	HICAN, etc.)	1	ck, White,	
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ING Z1Z15-U036  I filed within 72 hours after tal Hygiene.  I other than "natural", o event, the Medical Exam	Completed	(Specify only highest gra		(G.	ve kind of work done . DO NOT use retired)	during most of work	ing	16b. Kind of E	susiness in	dustry
Y withi	Be Co	12	Outlings (1 1 of o		<u>ephone ins</u>	taller		C&P Te	elepho	one
Maryland 21215-UU36 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last) Frank F. Magin				18. Mother's Name	, .		ne)	
Marylan 2 should be fill th and Mental 27 is marked of traumatic eve	ľ	19a. Informant's Name/Relationship (Ty	pe. Print)	19b M	ailing Address (Street				Stata Zin i	Cadal
		Dorothy Utz - sis			Bond St.,				State, Zip (	300e)
<b>Baltimore,</b> I bentified by a permit. Page 1 and 3 Department of Healt important: If item 2 any injury or other pnce.	185	20a. Method of Disposition  1 XBurial 2 Cremation 3	Demoval from State	20b. Place of Di	sposition (Name of rematory or other place		Date	20c. Location	- City or To	own, State
LIM E. Page tment tant: I	1	4 Donation 5 Other (Specific	<b>7</b>		Cemetery	8/26/		Westmi		<u> </u>
Baltimor permit. Page 1 Department of Important: If it any injury or o		21. Signature of Euneral Service Licens	w/	•	22. Name and Addre					Chapel, PA
		23a. Part 1. Ent the disease, or comp shock, or heart failure. List only or	lication that caused	the death. Do not						Approximate Interval Between
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	Ē	Sequentially list conditions, if y had global sequences cause. Enter Underlying	b. Dun to (or as a	eker consequence of:	4 1		- 120		- 4	xo grs
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r <b>bu</b> ate be executed physician and the burial-transi	교 교	resulting in death) Last	Due to (or as a	consequence of):	4			_		2 ~
ir <b>ou</b> icate be executed g physician and s the burial-transit	edical		d	n Conc	w					35%
certific	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d D	ate of deliv	erv
box death c he atter ed for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown		B	cy			onth	Day Year
that the ned by the detache		9 Unknown  Part II. Other significant conditions co		it not reculting in th	a underlying equee di	von in Port I	Log Pill			
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IVISION I or Attendin after death. Director: Aff	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, . (Specify)	street, factory, office		28f. Location (S City or Tow		er or Rurai	l Route Number,
DIVISION OF VITAL RECORDS, F.O. BOX 08/10 the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Phys	ician: To the best of e	my knowledge, dea	th occured at the time	, date and place, an	d due to the cau	use(s) and mann	ner as state	ed. use(s) and manner stated.
o the lathin 2 or the lathin 2 or the lathin 2 omplet	Me	only one) 3 Certifying Nurs  29b. Signature and title of certifier	e Practioner: To the b	pest of my knowledg	e, death occurred at th	e time, date and plac	e, and due to the	e cause(s) and m 29d. Date signe	anner as st	ated.
		Jam W. J.	huldlet	my This	7)20	7443		8/2	1_	U/U
ordet		30. Name and address of person who c	empleted cause of de	eath (Item 23a) (Type	e, Print)	oole Rd	2 Jules	townster	· 7	10 21157
Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	la d l		1			D 2/
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Amend Item 10a-g per estate 6914 sind Marial lawgiene
State of Maryland 7 Department of Health and Marial lawgiene
Amend 10b-10f per legal rep.

Certificate of Death

Reg. N. 200 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 23 Day PHOEBE JAMES MURDOCK 20ÎO 12:25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNAPOLITAN ASSISTED LIVING ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. . Social Security Number Funeral 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X**] F 90 Hours NOV. 30, 1919 FLORIDA Director 264-26-6080 Vrs Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b County Bristol 10d. Inside City Limits Director 1 XYes Z MARYLAND QUEEN ANNE'S STEVENSVILLE Wakefield Warren 10e. Street and Number 18 Washington Street 10f. Zip Code 10g. Citizen of What Country? Funeral 408 CONGRESSIONAL DRIVE 21666 UNITED STATES 02885 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X**No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 6 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: "natural", 3 Widowed 4 Divorced WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant. If item 27 is marked other tha ury or other traumatic event, the Mery or other traumatic event the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of the Mery of **EDITOR** PUBLISHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROLAND JAMES EDITH MACILVANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 CONGRESSIONAL DRIVE STEVENSVILLE, MARYLAND, 21666 CLARK MURDOCK/SON 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEARER) CREMATION AUGUST CENTER STEVENS VILLE, State Department of 1 Burial 2 X Cremation 3 Removal from State MARYLAND Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
LOG SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death .Physician/ Cardiopul monar disease or condition resulting in death) minutes Medical Due to (or as a consequence of): Examiner 40 cardia 20 minute Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 7/4 Car Hospital or Attending Physician: The law requires that the death certificate be executed 05 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Disease Airheimers 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🕦 Unknown Advanced 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Ityper lipidenia performed? 2X No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSISTED LIVING Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of car 29c. License number ပ 29d. Date signed (Month, Day, Year) D0032654 5 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) 2033 Penderbrooke pr., Crownsulle, MD 21032 Serlemitson MD 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 25 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Aug 26, 2010 ay Charles Henry Moore 03:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's Social Security Number 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 1**X**XM 2 □ F 82 577 38 7234 April 9. 1928 Mary Land Director Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Upper Marlboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2501 Ritchie Marlboro Road United States 20774 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married Completed by Yes 2 XX No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates. or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James H. Moore Frances A. Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Ritchie Marlboro Road, Upper Marlboro, MD 20774 Irma Moore (Wife) 20a. Method of Disposition
1 🔁 Burial 2 🗆 Cremation 3 🗔 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite any injury or ot 4 Donation 5 Other (Specify) Aug 30,2010 Clinton, Maryland Resurrection Cemetery Signature of Puneral Service 22. Name and Address of Facilities Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ rvostate caucinomA , recoverent disease or condition resulting in death) 2006 Medical Due to (or as a consequence of): Examiner 2008 Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tohacco use contribute to the cause of death? þ Polmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy atrial chronic within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 📝 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 042049 2010

State Registrar 31. Date filed (Month

MD

- Upper Mariboro.

20772

MO.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MPALOUX

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maurer AMonth 2010 MA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Olumbia Howard Mospital General 8. Date of Birth
(Month, Day, Year)
12 - 23 - 1943 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🗹 F - 9288 PA Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 🎦 No Ellicott City MD 10f.Zip Code 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral 21042 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. 1 Never Married 2 Married Completed by ☐ Yes Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced 4 Divorced Whi Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Administrative Assistant Health Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norris Harvey Rena Johnson and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Richard Maurer-Husband 10001 Whitworth Way Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Svc. 8/27/2010 Hanover, MD M01044Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician revo disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL CHAMIN and burial-trar Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.
To the Furnaral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv death? 1 🗆 Yes 2 🗆 No 2 | Nr Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 🗆 No Certificate: To 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Aug 25, 2010 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 \_\_,Natural 2 Accident work? 5 Pending 2 🗚 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Regie Number Suicide ace of Injury - At home, farm, steet, factory, office building, etc. (Specify) determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) & Amel Jaup Im D38558 21,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 10700 Charter Brive Columbia # 100 4015 DM egistrar's Signatur State Registrar

Etta Jane Oluyole State of Maryland / Department of Health and Mental Hygiene 2010 28797 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day 2040 hrs Medical Examiner Jane ()luvole September 1, 2010 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Cívista Medical Center La Plata Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Washington Country) **Funeral** 577.92.6793 Hours Director 1 M 2 F 10a. State 10c. City, Town or Location Plains 10d Inside City Limits 1 Yes 2 No Charles death with the Maryland Director 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 20693 10009 1354 Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married Never Married 1 Yes Pages 1 and 2 should be filed within 72 hours after or the feath and Mental Hygiene. 3 Widowed 1 Yes 2 No specify: 4 Divorced If Yes, Give Year ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Important; If item 27 is marked other than injury or other traumatic event, the Medical ansportation Specialis 17. Father's Name (First, Middle, Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20695 White Plains, MD . Husband Warnsley 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial 2 1 Cremation 3 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 4594 Beech Freeman Funeral Svos Temple Hills, MD 20748 notreeman complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and /Medical Cardiac Arrhythmia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, pt.II,27 per me g908 10-15-10 vt ed by the attending physician a detached for use as the burial -**X** UNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Ö ξ σ. 1 Yes 2 No 3 Probably 4 V Unknown Alcohol Abuse page 2 should be Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other this 1 Yes 2 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 X Natural 1 Yes 2 No within 24 hours after death. To the Funeral Director: Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Q.C.M.E. September 3, 2010 30. Name and address of person who completed cause of death (mem 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Yea. State Registrar

			State of Maryland / Dep			Mental Hy	giene	20700
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of E	<i>Death</i>		Reg. No.	28798
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1	)		6804 Dry Log St.	Capitol			Prince	
	Funeral		6804 Dry Log St.  5. Social Security Number  6. Sex 1 □ M 2 ☒ F  1. Age (In yrs. last birthday)			s. 8. Date of Birt	th g.	Birthplace (State or Foreign Country)
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	a or 2	al Di	10e. Street and Number	10f. Zip Code			10g. Citizen of Wha	t Country?
	th wit ms 23	Funeral	6804 Dry Log St.	20743			USA	
	or iter		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- rto Rican, etc.)		American Indian, Vhite, etc.
930	safte ral", c Exan	q pe	3 X Widowed 4 Divorced   If Yes, Give Year or Dates.	1 Yes 2 X No	Specify:		Specify:	Black
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Baltimore,	t. Pag tment tant; ijury o		4 □ Donation 5 □ Other (Specify) Lincoln N	Memorial C			Suitlnad,	
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Addres Marshall s 4308 Suitl	Funera and Rd.	1 Home of Suitlan	f Maryland	i 0746
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying	g, such as cardia	c or respiratory arr	rest,	Approximate Interval Between
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89	death certificate be executed re attending physician and ed for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of	deliven
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Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (S City or Tow		Rural Route Number,
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	F ≥ <b>F</b> 8		290. Signature and title of certifier	D247			Aug. 31,	
R	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Syed Sadiq, MD 14333 Laurel Bowie I	,	Laure.	Md. 207	08	
	Stat	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature			-		
	Registra	ır	SEP 0 1 2010 Server S. Garket					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Donovan PRICE 3117 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 26,1940 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Hours 220-42-5810 69 Director Yrs. Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Boonsboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7748 Fairplay Road 21713 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. β 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 K No Specify. white Specify. Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) transportation truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester Allen Price Nancy Elizabeth Sowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Patricia Price - wife 7748 Fairplay Road, Boonsboro, Md. 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Salem Lutheran Ch.Cem, 9/3/10 Bakersville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Ulmanary disease or condition Medical Due to (or as a conservence of): Examiner eumonia Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for seig our sague, ne un attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 2 No 1 ☐ Yes 2 1 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Carcinana 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed After this certificate 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. **Director**; After this certifical in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မှ 1 Dempatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number well Decesed 4(006/17 31 2019

State

Registrar

Francisco

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Physicia /Medica		1. Decedent's Name (First, Middle, La Annie D. Rhea					2. Date of Death Month August 2	28,2010	3. Time of Death 10:50A
Examine Funeral Director		4a. Facility Name (If not institution, given Cherry Lane No. 5. Social Security Number 245–48–8942	ursing Ce	(In yrs. last bir	Laurel	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Sept • 3	4c. County of De P. G. (9. E. (1929) 5. E. (	
D	tor	Usual Residence of Decedent  10a. State  Md • P •		10c. City, Towr	or Location stville		-		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th with the 23a or 28a ist be noti	al Director	10e. Street and Number 2000 Whittaker	Court		10f. Zip Code 20747		'	g. Citizen of What	Country?
al", o	by Funeral	11. Marital Status  1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hif Yes, specify Cub		ecify Yes or No- Rican, etc.)	Black, W	nerican Indian, nite, etc. 31ack
within 72 ho ene. than "natur h. Medical i	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 8th	ducation ade completed) College (1-4or 5+		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Domestic	oation during most of work d)	ing	6b. Kind of Busines	Families
2 should be filed variant Manuard Manuard Hygie is marked other traumatic event, th	To Be Co	17. Father's Name (First, Middle, Last William Mitc		ms			e (First, Middle, Ma	aiden Surname)	rta York
and 2 should the alth and Ment in 27 is marked the tranmatic the tranmatic the tranmatic the alth and the alth alth alth alth alth alth alth alth		19a. Informant's Name/Relationship ( William Rho	Type. Print) eams./Son	i	Mailing Address (Street)	ker Cour	t Fores		
Pages 1 tment of He tant: If iten jury or oth		20a. Method of Disposition  ★ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	y)	20b. Place of	Disposition (Name of ry, crematory or other pla ony Memori	al Sept	Date 20	oc. Location - City	or Town, State
permit. Pag Department Important: any Injury once.		21. Signature of Funeral Service Lice	obinso	Dr.	22. Name and Addre	n Funera	Wash I Home	P3F3 66	0001 h St.N.W.
cate be	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	b. Advance Due to (or as a	consequence of consequence of Renal	ementia on: Failure				Onset and Death
death cerr	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify)	у		23d. Date of o	lelivery Day Year
res the signe be d	ğ	Part II. Other significant conditions of Thromboc		not resulting in	the underlying cause giv	en in Part I.	23e. Did toba		to the cause of death? Probably 4 □Unknown
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within 24 hours after or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical or Merical	edical Ce	29a. Certifier (Chack only one)  1   Certifying Ph 2   Medical Exar	ysician: To the best of niner: On the basis of e and manner state	examination and	, death occurred at the ti d/or investigation, in my	me, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner te and place, and c	as stated. ue to the cause(s)
within To th compl	Me	29b. Signature and title of certifier	2		29c, Licens	5964 9	70	d. Date signed (Mo	
4		30. Name and address of person who Ikechukwu Mbc			Type, Print) Armory Pla	age Pel	timoro	M-Z 21	204
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. edent's Name (First, Middle, Last)\_ 2. Date of Death RUMEU Physician/ Month 1820 M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Annapolis Somerford Place 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 6 Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 1 D M 2 F 90 07/90694920 WaSHTAgton, D.C. 577-20-4446 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Annapolis Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 United States 2717 Riva Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Manital Status 14. Race - American Indian. Armed Forces 7 Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Specify: White 3 Widowed 4X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 and Mental Hygiene. is marked other tha Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William J. Howard, Sr. Edna Hillyard permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Romeo/Daughter 1727 Harbor Drive, Chester, Maryland 21619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Olivet Cemetery 09/01/2010 Washington, D.C. 4 Donation ✓ □ Other (Specify) 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a, Part 1 Inter the disease, or complications that cause, show, or heart failure. List only one cause on each lin Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Þ The law requires Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed? Yes 2 To the Hospital or Attending Physician:
Within 24 hours after death.
To the Funeral Director: After this certific Completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence IMERFURI 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of PLACE Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending Division 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1+ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 21438 10 completed cause of death (Item 23a) (Type, Print Name and address of persont who ANNAPOLIS MOLIYOI N77 W 445 DEFENSE HIGHWAY

DHMH 17 Rev 7/2009

Registrar

Box 68760

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of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Dorothy Ann Rice 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death, Hospice At the Lake Wicomico 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 □ M 2 🕱 F Months Days Hours Min. 08429 PIYYZI Director 88 220-03-2953 Maryland Usual Residence of Decedent 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 323 New York Ave. 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes : 2 👿 No Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 3 →Widowed 4 □ Divorced 1 ☐ Yes 2 🙀 No Specify: Specify: Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be Charles Benjamin Dixon Grace Viola Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 323 New York Ave., Salisbury, MD 21801 Carol Smith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a Date 1 🔼 Burial 2 🗀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 08 30 2010 Baltimore, Maryland Signature of Funeral Service Licenses Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23á. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death DBMBN Physician/ TIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 ☐ Yes 2 🗷 Ro 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No OSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 5  $\square$  Pending injury work? 1 □ Yes 2 □ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugus 130 )35 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Daltimol permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Ser			Ches	sapeake 22.	Cremato Name and Addres H.S.Wa	ry 156 is of Facility Ashing	ton	& Sons	Co.	.Tnc.	e,Mo	C. 20019
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7		30. Name and address of pe	rson who co		eath (Item :	 23a) (Type, Pr		690	7		tuai	177 (	25	2010
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20°10 Barbara Shifflett 8:50 P M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3705 D Penny Lane Abingdon Harford 8. Date of Birth (Month, Day Ye June 10, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) 1961 Days 1 M 2 X F Maryland 49 Director 215-54-2649 Usual Residence of Decedent 23a or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Abingdon Maryland Harford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 3705 D Penny Lane USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 📉 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Mechanic injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barbara Ann Bandorick ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked David Roland Dyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Dogwood Ave, Edgewood, MD 21040 Jennifer Barlow, daughter 20b. Place of Disposition (Name of Evergreen compatory or other place)
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 8/27/2010 Finksburg, MD 4 Donation 5 Other (Specify) Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any 91 Willis Street, Westminster, MD 21157 istair Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ END STAGE (20 P C) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

g ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Yes 2 No this certificate has been signed by the rail director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MIH Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 2 No prior to completion of cause of death? 1 Yes 2 No **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\overline{X}\) Residence 6 \(\sum \) Other (Specify) 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completed filled in by the fun. 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🚝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL 8/24/10 U0020803 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WITE IN BEL ALL STULY PHILL W. HALVIERS BE BECOMTA NTUES 200 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State AUG 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

P.O.

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia		Registrar  1. Decedent's Name (First, Middle, Last)	:lin STOCKSLAGER	rtificate of L	Jeatn	2. Date of Dea	30°, 2010	32imoorbeau 5
Medic Examin		4a. Facility Name (if not institution, give street at 10814 Clinton Avenue	nd number)	4b. City, Town, or Hagers	r Location of Death		4c County o Washi	of Death .ngton
Funeral Director		5. Social Security Number 218-24-1748 6. Sex 1 区 M 2	T. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug • 3 •		9. Birthplace (State or Foreign Country) Maryland
faryland 8a-f show tified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Washington	10c. City, Town or Lo Hagerstow					10d. Inside City Limits 1 ☐ Yes 2√ No
s 23a or 2 ust be no	Funeral Dir	10e. Street and Number 10814 Clinton Avenue		10f. Zip Code 217	40		10g. Citizen of Wi	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 If Y	ned Forces?	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎛 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, s, White, etc. white
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d 2 should laith and N n 27 is ma er traumai		19a. Informant's Name/Relationship (Type, Prin Patricia A. Wishard -		-	and Number or Rura		•	
Page 1 and ment of He tant: If iten iury or other	(i (i)	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	Rest Hav	natory or other place en Cemete	Septo	ember 2010	Hagerst	Oity or Town, State
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1-10		30. Name and address of person who complete		Print) U Med	tical Co	mw	these-	hun MO
Stat	e	31. Date filed (Month) (a Dyell) 1	32. Legistrar's Signature					

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State	tate of Ma	aryland /			lealth and I	vientai Hy	giene 201	0 28806
		Registrar  1. Decedent's Name (First, Middle, Last)			Cen	tificate of L	<i>Jeatn</i>	1	Reg. No.	
Physician Medica			ıde E. S	peck				2. Date of Dea Month August	Day	3. Time of Death 910 8:05 P M
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and show	5	10a. State 10b. County		10c. City, Tov	wn or Loca	ation		*		10d. Inside City Limits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1	oval from State	cemet	ery, crema	ition (Name of atory or other place		Date 2010		City or Town, State
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Physician/		23a. Part 1 Inter the disease, or complication shock or heart failure. List only one call immediate Cause (Final disease or condition	u e on each line.	the death. Do		•	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
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or Atte	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injur building, etc.		farm, stree	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner: 0 only one) 3 Certifying Nurse Pra	In the basis of ex	amination and	/or investig	gation, in my opinic	n, death occurred a	at the time, date a	nd place, and due t	to the cause(s) and manner stated.
To the within Comp		29b. Signature and title of certifier	)/	no		29c. License	6242		29d. Date signed (	(Month, Pay, Year)
	ŀ	30. Name and address of person who completed the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	eted cause of de	ath (Item 23a)	(Type, Pri	int 1 - 1 - 1	la D	Pit	11.110	10 2000
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death ARJORITE Physician/ 1720 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL GINGER COVE ANNAPOLIS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Year) 1<u>922</u> 1 M 2 F Months Days Hours Min. NOV . I I 87 **Director** 216-22-2771 NEW JERSEY Usual Residence of Decedent or 28a-f show notified at 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 ☐ No MARYLAND ANNE ARUNDEL ANNAPOLIS 23a or 2 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe Funeral ural", or items 23a I Examiner must b 4000 RIVER CRESCENT DRIVE 21401 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force þ Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2+ HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FLOYD NEWTON ROBB MARJORIE NEWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY PAYNE/DAUGHTER 21A QUEEN VICTORIA WAY, CHESTER, MARYLAND 21619 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ₽ <u>∓</u> STEVENSVILLE, MARYLAND 1 Burial 2 X Cremation 3 Removal from State 24, CREMATION 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 106 SHAMROCK ROAD, CHESTER MARYLAND 21619 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and gently Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year Unknown 9 Unknown ate has been signed by tage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? performed? Yes 2 No 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 6 Other (Specify) N/+ examiner? Hospital 1 Yes 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. after death

Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a

To the Funeral D Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b Signature and title 29c. License number 21438 ne and address of se of death (Item 23a) (Type, Print) 110 H 44TD28-ENSE

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month Physician/ 4:10 P M William C. Spencer 2010 Medical Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. Çity, Town, or Location of Death ICO mico Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **⊠** M 2 □ F Hours New York Director 064-28-8708 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 4725 Dividing Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces? or i Black, White, etc. 1 Never Married 2 Narried δ 1 X Yes William Dence 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Completed Year or Dates. Army White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) New York Department of Elementary/Seconday (0-12) College (1-4 or 5+) Corrections Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henrietta Smith Clarence Spencer it. Page 1 and 2 shours of Health and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Spencer |wife 4725 Dividing Rd., Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Department Important: It 08 27 2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, Maryland Signature of Funeral S .22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Licensee Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ALZHEIMAN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 50N Sequentially list conditions. il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exam ng physician and as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE: ase a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown P.O. I is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law has page 5 prior to completion of cause of death?

1 Yes 2 No autopsy certificate l Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this ompleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 00058

Registrar
DHMH 17 Rev 7/2009

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21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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32 Registrar's Signate

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Albert D. Santor 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Medicul Cont COMK Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F 172-30-6748 Days Months Hours 71 OTYO79Y939 Director Pennsylvania Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Northumberland Direct Coal Township Pennsylvahia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1724 Raven Ave ed other than "natural", or items 23 event, the Medical Examiner must 17866 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give white 3 X Widowed 4 Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Director of elections county government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Albert Santor Helen Kovaleski permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 Raven Ave., Coal Township, PA 17866 Stella Morris/ fiancee timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
All Saints Cemetery 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/1/2010 Elysburg, PA 4 Donation 5 Other (Specify) Signature of Funeral Service Libensee Bal Thornoway Fundral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or commencations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NEERION WALL MYSCAROAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to for as a consequency of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Day Year page 2 should be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 2 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Hospital Other: မှ 1.XInpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending injury 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 € 31. Date filed (Month, Day, Year)

State

Registrar

AUG 3 v

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registramen # s21 22 PerFHPCC9-1-10cm 28810 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Townes Gloria Woodson 2010 August 4:00 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4907 Eastern Avenue: Apt. Hyattsville Prince Georges Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1938 November 26, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days Hours Months West Virginia Director 578-60-2426 71 Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince Georges Hyattsville 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral 4907 Eastern Avenue; Apt. 311 20782 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 X No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade Housewife Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Elbert Woodson, Sr. Julia Smith other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a ant; If item 27 is Lisa Bonita Milligan (Daughter) 1702 Shell Road; Hampton, Virginia 23606 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite Augus te 28. 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place, any injury or 4 Donation 5 Other (Specify) **Cedar Hill Cemetery** 12010 Suitland, Maryland 21. S nature of tuneral Service Licensee 22. Name and Address of Facility N. Horton Company Morticians, SIEWART F. H. /4001 BENN TRUNCE STEWART F. H. /4001 BENN N. Washington, D. C. 20019 under 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Breast Cancer Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir ending physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Renal Failure that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Day Year hed 9 X Unknown signed by to I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy perform death? 1 Yes 2 No completed filled in by the funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛣 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a, Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W D46998 25, 2010 August

State Registrar 31. Date filed (Month, Day, Yea **SEP 0 1** 2010

Steven T. Tee, M.D.; 3415 Hamilton Street; Hyattsville, Maryland

20782

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 20ÎÖ LORNA WHYTE Medical 1:30 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES CLINTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Min. MAY 9 1937 Director 231-42-9492 73 CANADA Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Tyr Yes 2 No MD PRINCE GEORGES CLINTON ö 10e. Street and Number ems 23a or must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 7520 SURRATS ROAD 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, ŏ ş 1 X Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 Divorced Specify: CAUCASIAN Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) Il Hygiene. College (1-4 or 5+) WAITRESS RED LOBSTER other traumatic event, Be 17. Father's Name (First, Middle, Last) and Mental F is marked o 18. Mother's Name (First, Middle, Maiden Surname) ဂ UNKNOWN ROSSALYN DEVINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $17587\ MEADOWS\ DR.,\ ABINGDON,\ VA\ 24210$ Department of Health ar Important: If item 27 is any injury or other trauonce. DONNA JENKINS/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) METROPOLITAN CREMATORY08/26/2010 ALEXANDRIA, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility MARSHALL S FUNERAL HOME 21. Signature of Funeral Service Licensee SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE Lung Physician/ CHRMIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the at Id be detached fo Pregnant at time of death Day Year g Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s 24a. Was an has autopsy hours after death. uneral Director: After this certificate performed? Yes 2 Wo filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Tes 2 4NO Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Hospital Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livington Rod, Fort WASHing Ton JANNER MID lliam

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

SEP 0 1 2010

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cheryl Lynn Worden September 2,2010 5:02 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5702 Nottingham Place Adamstown <u>Frederick</u> Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. July 27 Mary Land 218-80-6951 51 Director Yrs Usual Residence of Decedent or 28a-f shown notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits Maryland Frederick 1 X Yes 2 No Adamstown 10e. Street and Number 10f. Zip Code ems 23a or 10g. Citizen of What Country? Funeral 5702 Nottingham Place 21710 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. fitem 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Asst. Defense Contractor Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles F. Shearer Bonnie J. Thrasher Shearer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Worden/ Husband 5702 Nottingham Place Adamstown, MD 21710 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State injury or Smithsburg Crematory 9-3-2010 4 Donation 5 Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Eastern Blvd. Ν. Hagerstown MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death 3/755 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Day signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been siç ; page 2 should k Completed 1 ☐ Yes 2 🗪 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed?

Yes 2 Mo prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ♠No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 1014676 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar
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State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar 28813 Certificate of Death Reg. No. Decedent's Name (First Middle Last 2. Date of Death Williams August 10.10A M 2010 Facility Name, (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death hestertown 5 Social Security Number If Under 1 Year | If Under 24 Hrs Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Min 1 M 2 X F Days Hours 216-48-8001 Yrs. MARYLAND FEB.6.1947 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2□No MD **QUEEN ANNE** CENTREVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 614 MURPHY ROAD 21617 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2X No Specify. Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 -0-HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RAYMOND JORDAN DOROTHY KANUS 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAYMOND JOHN WILLIAMS, III/SON 210 BEAVER DAM ROAD, HENDERSON, MD 21640 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State WOODLAWN MEMORIAL PARK AUGUST 30, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 EASTON, MD 21601 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 rert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS HOURS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Unisease or highly that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? METASTATIC LUNC CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy nerform 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ⊟Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Physician** /Medical Examiner

permit. Pages
Department of
Important: If it
any injury or c

**Physician** 

Examiner

**Funeral** 

Director

28a-f show be reutified at

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
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Saltimore, Maryland 21215-0036

Director

Funeral

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Be Completed

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/Medical

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requires that the death certificate be executed

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Physician:

the Hospital or Attending

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24 hours after death e Funeral Director: in by the

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Division of Vital Records, P.O. Box 68760,

Examine and attending physician for use as the burial Physician/Medical signed by the a ģ icate has been si , page 2 should b Completed certificate Be After this funeral

Certification: To

Medical

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Kramun

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0066441

STREET, CHESTERTOWN

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) AUGUST

25 2010

21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMESH

100 BROWN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LORIA DISHAROON WARWICK Medical Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death 5/0 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗷 F Months Days Director Usual Residence of Decedent 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Fes 2 No MA 2100Mica 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral OT CLYDF 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: 3 Divorced Completed Baltimore, Maryland 21215-003 WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetin. Elementary/Seconday (0-12) College (1-4 or 5+) -LORIST FLOWFRS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 3. DISHARCON IV 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15Ruzy,mp 2180° 20c. Location - City or Town, State DEVIN WARWICK (SON 12 RIVERSIDE DREXT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SINDAM (EMETER) 8-23-2010 SALKBURY MID 21. Signature of Funeral Service Licensee 22. Name and Addras of Facility m00416 MBSICK FUNERAL HOME PORXGI BIVALVEMDZIRIL 23a. Part Finter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CARCINDONA disease or condition resulting in death) MALIGNANT Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to impose cause. Enter Underlying Examiner Due to for as a consiguence of and -transit law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Dav Year as been signed by the 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has I page performed? Yes 2 No Physician: The 1 Yes 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Matural Natural injury 5 Pending s after death. 2 Accident 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atturan 10 Box 733 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 Registrar

Anna Wade		1- For State	tate of Maryla		artment o ertificate o		d Mental		Reg. No. 20	10 2881
Physici Medical Exami		1. Decedent's Name (First, Mid						Date of De     Month	eath Day Year	3. Time of Death 1634 hrs
Wedical Exami	IIGI	ANNA 4a. Facility Name (if not institute		WADE mber)	1	4b. City, Town, or	Location of D		per 6, 2010 4c. County of E	
		Prince Georges Hosp	oital Center			Cheverly			Prince Ged	orge's
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Yea  Months Days		Min.		oreign
Biredior		579-86-5670 Usual Residence of Decedent	1 M 2 XF	50	) Yrs			JAN.	21, 1960	Countr WASH. D.C
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ne Maryland or 28a-f show any fred at once.	)irec	10e. Street and Number				10f. Zip Code			10g. Citizen of What	
ath with the items 23a	al	451 BERBAN 11. Marital Status	12. Was Dec	edent Ever in U			panic Origin?	( Specify Yes or N		merican Indian, 8lack,
death or iten	<b>Funeral Director</b>		Armed Fo	2 X No	lf Y	es, specify Cuban		erto Rican, etc.)	White, e	c.
thours after de "natural", or	ò	3 Widowed 4 Di	vorced If Yes, Give Year or Dates:		1	Yes 2 X No		of work done	Specify:	BLACK
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ones.		MILDRED D. AN	TOINE/SIST			CLASSIC		, SILVER	SPRING, I	
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Baltim permit. Pa Departmer Importam injury or		4 Donation 5 Other S 21. Signature of Funeral Service		GI		CEMETERS ame and Address		·10-2010	CREMATORII	ron, D.C.
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A STATE OF	Ļ	Sequentially list conditions,	b. Due to (or as a		0					
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In the difference of the state	Exa	events resulting in death) Last	Due to (or as a d.	consequence o	rf):					
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8760 ificate ling physis the by	N N	IF FEMALE: 23b. Was decedent pregnant in t	∠3c. if yes, o	utcome of preg	nancy	al death 3	Ectopic pre		23d. Date of deli Month	very Day Year
Box 6876  - death certificate the attending phy cd for use as the l	Physician/M	past 12 months?  1 Yes 2 No 9 ✔ Un	4 Pregna	nt at time of de	oth -	er (Specify)				
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	d b	Fatty Live	r					1Ye	es 2 Nc 3 🗸	Probably 4 Unknown
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Reco	Ĕ								ormed? death 2 No 1	
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ion (tending eath.	atio	1 X Natural 5 Pend 2 Accident Inve		Day,Year)		1 Y	es 2 No			
Divisior ospital or Attend hours after death uneral Director:	Certification:	3 Suicide 6 Cou	d not be 28e. Place	of Injury - At ho	ome, farm, stree	, factory, office bu	uilding, etc.	28f. Location ( or Town,		Rural Route Number, City
Flospita 4 hours 7 unera		29a. Certifier 1 Continue D	rmined (Specify)  hysician: To the best	of my knowledg	ne. death occurr	ed at the time, dat	te and place, a	and due to the cau	se(s) and manner as s	stated.
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medical Exa	miner: On the basis of and manner sta	examination a						
F 5 F 3	ž	29b. Signature and title of certific				29c. License			29d. Date signed (	
	-	Hamula Thur 30. Name and address of person	hell, mi)	of death /lin-	23a)	O.C.N	1.⊆.		September 7,	2010
		Pamela E. Southall, N				Penn Street,	Baltimore	, MD 21201		
St Regist		31. Date filed (Month, Day, Year) SEP 1 4 2010	32, Reg	istrar's Signatu	ire all				<del></del>	

10-06698
Leonel Zaldana

Leonel Zaldana		S - For State legistrar	tate	of Maryland			t of He e <i>of De</i>		nd Men	ital Hygid		eg. No.	20	10	28816
Physician/ Medical Examine	7	Decedent's Name (First, Mide				_				l N	ate of Deat lonth eptembe	Day	Year		3. Time of Death 1530 hrs
)		Leonel 4a. Facility Name (if not instituti		aldana e street and number	)		4b. Cit	ty, Town, or	r Location o		spiembe		. County of	Death	
	Ļ	3034 Huron Street	Г					Itimore	- Lance in	T-					
Funeral Director	L	S. Social Security Number None	6. Se	7. As	ge (In yrs. Ia 49	ist birthda		Inder 1 Yea		100	07/21,			Foreign	nplace (State or El Salvado ntry)
any	_	Usual Residence of Decedent  10a. State 10b. County			10c. City,	Town or L	ocation							_	10d. Inside City Limits
and Fshow	<u>.</u> [1	Maryland			Balt	imor	æ								1 X Yes 2 No
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		1. Marital Status 1. Never Married 2. 1		12. Was Deceden Armed Forces' 1 Yes 2 If Yes, Give Year				ecify Cuba	n, Mexican	gin? ( Specify , Puerto Rica Salva	n, etc.)		14. Race - White, Specify:	etc.	an Indian, Black,
nurs after amines		15. Decedent's Education (Spr		or Dates:	mpleted)	16a. Dec	edent's Us	ual Occupa	ation (Give	kind of work			Kind of Busi		
5-0036 ed within 72 hour hygiene. other than "natu the Medical Exar Cormpleted		Elementary/Secondary (0-12)		College (1-4 or	5+)		ng most of ISTYUC	_	e. DO NOT	use retired)		Se	lf Em	plo	yed
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MD 21 nd 2 should alth and Me on 27 is ma aumatic ev	Ľ	9a. Informant's Name/Relation Cristina Zalda:				303	34 Hui	con St	t. Ba	nber or Rural 1timor	e, MD	21	330		
Baltimore, permit. Pages I an Department of Hea Important: If iter njury or other tri		20a. Method of Disposition 1 ☑ Burial 2 ☑ Crematio 4 ☑ Dona <b>ro</b> h 5 ☑ Other S	_	Removal from St			isposition (I or other pla Heav			09/09		l		•	ing, MD
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OX 6876 eath certifical attending ph for use as the	2	F FEMALE: 3b. Was decedent pregnant in t past 12 months?  1 Yes 2 No 9 Ur	he known		me or pregna	2	Fetal dea		Ectopic	c pregnancy		230	d. Date of d	Da	ay Year
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Vital hysician this cert directo	Ш	examiner? 1 ✓ Yes 2 No	H	ospital: 1 Inpatie	ent 2 🗌 E	ER/Outpa	tient 3	] DOA	Other:	Nursing Hor	ne 5 [] 1	Reside	nce 6 🗸	Other:	Scene
n of Vi ling Physi After this funeral dir		7. Manner of Death  1 Natural 5 Dear		28a. Date of Inju (Month, Day,)	iry 'ear)	28b. Time	of Injury		ry at Work		Describe h	ow inju	ry occurred	t	
ivisior or Attenc after death Director: I in by the		2 Accident Inve	ding stigatio	fd 9-5- 28e. Place of Ir			street fact	1	Yes 2 X	S					nedication al Route Number, City
Division o spital or Attending tours after death. neral Director: After filled in by the func Certification:			ld not b rmined	oe	ijai y - At Hoi	hous		ory, ornoe i	Janany, ea		or Town, St	ate)			to, Md.
Division  To the Hospital or Attent within 24 hours after death  To the Funeral Director: completely filled in by the		9a. Certifier 1 Certifying P		an: To the best of mo	-	e, death c	occurred at			ice, and due t	o the cause	e(s) an	d manner a	s stated	1.
To with To con	2	9b. Signature and title of certifi	er (	N				29c. Licens					Date signed tember 6		h, Day, Year)
RI	103	0. Name and address of person Margarita Koreli MD.		completed cause of calls		,	1 Penn S	<u>-</u> -		, MD 2120	)1			,	
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State of Maryland / Department of Health and Mental Hygiene 288 | 7

			State Registrar		Cer	tificate of [	Death	_	Reg. No.	
f	Physicia Medio		1. Decedent's Name (First, Middle, Las Margaret J					2. Date of D	eath 11, Day2010 Year	3. Time of Death 8:35 pm M
	Examir		4a. Facility Name (if not institution, give	·		4b. City, Town, or		eath	4c. County of Death	
-60	Funeral		5. Social Security Number 6. Se		st birthday)	If Under 1 Year Months Days	If Under 24 H		Baltimore irth Bayear 1919 Macou	nplace (State or Foreign
	Director		075-14-7746 1 Usual Residence of Decedent	□M 2 M F 91	Yrs.			oune".	1919 Mar	ntv) yland
	Maryland 28a-f shov	Funeral Director	10a. State 10b. County  Md. Baltimo:		Town or Loc	n				10d. Inside City Limits 1 ☐ Yes 2 ♣ No
	h with the s 23a or nust be n	neral D	10e. Street and Number 2203 Wiltons	wood Rd.		10f. Zip Code 21153	3		10g. Citizen of What Cou	untry?
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Manital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 24 No If Yes, Give Year or Dates.	lf 1	Yes, specify Cuba	Specify:	(Specify Yes or No lerto Rican, etc.)	Black, White	
Maryland 21215-0036	within 72 ho giene. her than "na t, the Medic	<b>Completed</b>	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give k	ent's Usual Occup ind of work done of NOT use retired) 15ewlfe	ation during most of v	working	16b. Kind of Business I	·
yland	nould be filed within 72 ind Mental Hygiene. s marked other than " umatic event, the Mes	To Be	17. Father's Name (First, Middle, Last)  Charles Gibs	son McGill				Name (First, Middle hleen Cut	e, Maiden Surname) tlip	
e, Mar	and 2 shou Health and Im 27 is m her traum		19a. Informant's Name/Relationship (Tight) Rebecca Hoffberge	er - Daughter	17 E	Barnstabl			er, City or Town, State, Zip Mills, Md. 21	1117
Baltimore,	t. Page 1 atment of hardent: If ite		20a. Method of Disposition  1	Removal from State Mary	netery, crem vland V				20c. Location - City or 10 Owings Mi	ills, Md.
Bal	permit Depar Impor any in	l l	21. Signature Fu eral Service Licens	ed f	22	Name and Address Ckhardt 1605 Rei	s of Facility Funera sterst	l Chapel,	P.A. Owings Mills	21117 s, Md.
	Physician/ _Medical		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death ne cause on each line.  a. Due to (or as a conseque	. Do not ente	r the mode of dyin	g, such as card	liac or respiratory a	ırrest,	Approximate Interval Between Onset and Death
	Examiner pa tisu	miner	Sequentially list conditions, if any, leading to mandate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a conseque	ence orj.					
90	rtificate be executed ing physician and e as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):					
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live Birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnanc Other (specify)	sy		23d. Date of deli Month	very Day Year
ds, P.O.	luires that to an signed bould be deta	ed by P	Part II. Other significant conditions co	ontributing to death but not resu	ılting in the ur	nderlying cause giv	en in Part I.		tobacco use contribute to	
Division of Vital Records,	Physician: The law rec this certificate has bee al director, page 2 sho	Complet						perf	opsy prior to c formed? death?	opsy findings available ompletion of cause of
tal	cian; sertifica setor, j	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (C		202 110	
Ϋ́	Physi this c	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ E	R/Outpatient 28b. Time of	DOA Othe	Nursin		idence 6 Other (Special	(y)
ion o	tending death. tor: After the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 ☐ No	Zod. Describe	now injury occurred	
Divis	oital or Al urs after or al aral Directilled in by		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				City or To	(Street and Number or Rura wn, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination the Practioner: To the best of my	and/or investi	gation, in my opinio	n, death occurr	ed at the time, date	and place, and due to the c	ause(s) and manner stated.
	<b>6 ≱ 6</b> 8		29b. Signature and title of certifier	< MD		DO O	number 5 3 1 S	50	29d. Date signed (Month, SEPT 13	ZOIO
			only one) 3 Certifying Nurs  29b. Signature and title of certifier  Source  30. Name and address of person who ce  Shelen mo  31. Date filed (Month, Day, Year)  SEP 15 2010	ompleted cause of death (Item :	23a) (Type, Pr 965.	int) OSKno	hicfo	Rd Si	cite 110 olumbre	21045
	Sta Registra		31. Date filed (Month, Day, Year) SEP 1 5 2010	32. Registrar's Signatu	parke	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 4.00 PM SEPT. 2010 Jan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE AGNES HUSPITAL 8. Date of Birth Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months -54-3416 Davs Yrs. Director th Cardina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience outer the medical and injury or other traumatic event, the Medical Experience outer the medical and injury or other traumatic event, the Medical Experience outer the medical and injury or other traumatic event, the Medical Experience outer the medical and injury or other traumatic event, the Medical Experience of the medical and injury or other traumatic event, the Medical Experience of the medical and injury or other traumatic events. 1 Xes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number WIIKens Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 1 □ Yes 2 □ 3altimore, Maryland 21215-0036 Specify. Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ mainenlance 1214 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) #10 reld 3400 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 16 da 22. Name and Address of Facility re of Funeral Service Licens Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyirig, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): attending physician Physician/Medical the SB IF FEMALE: for use a If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ DEMENTIA 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📈 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: sompletely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO D6062634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATERN 10796 HICKORY RIDGE DO CLLUMBIA AWAN MO 21044

State Registrar

CEP 1 5 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of Ferson who completed cause of death (Item 23a) (Type, Print)
Peter Smith, MD 9000 Franklin Square Dr Balto. MD 21237

9-13-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0556 AM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 13, 1942 Sex 1 M 2 D F 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Months Hours 214-38-6602 Baltimore, MD. Director 68 Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No Maryland Anne Arundel Co. Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21032 774 Paul Birch Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 is marked other than "natural", 3 X Widowed 4 ☐ Divorced White Year or Dates. Peacetime 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Aircraft Manuf. 12 01 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Hilda Morris Gordon Wilson Ashley, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Woodland Drive Jacobus, PA. 17407 Mr. Timothy E. Ashley (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chancel and
Cremation Services, Inc. (Harford Co.)
Forest Hill, Maryland 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State Sept.15,2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic CANCEY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate 2 4No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 🗌 Yes Accident Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 064089 13/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (al Parkuay Angralis anc MD 2001 Medi 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

P.O. Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical **Examiner** Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Salti 8. Date of Birth (Month, Day, If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign MM 2 IF Days Hours Min. Ve :- th Director Yrs Usual Residence of Deceden 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Magland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married <u>Ş</u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 NWidowed 4 Divorced Completed K Car 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ္ Mabl Barnes rnest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Blue Whode injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) remotor 21. Sture of Funeral Service Li 22. Name and A ress of Facility 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, reaching to immediate cause. Enter Underlying Examiner Due to (or as a consequer es of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last 124 hours after death. e Funeral Director, After this certificate has been signed by the attending physician and Netron filled in by the funeral director, page 2 should be detached for use as the bunal-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

SEP 1 5 2010

and address of person who completed cause of death (Item 23a) (Type, Print)

10-06995 Bobbie Bullock

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 28822

		constate Certificate of Death Reg. No.							
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last)	Date of Death     Month	Day Year	3. Time of Death 1740 hrs				
		DUBBLE SELVI BUILDER	Town, or Location of Death	September	4c. County of Death				
		2425 Westwood Avenue Balti	more City						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unc	der 1 Year   If Under 24Hrs	_	(MM/DD/YYYY) 9. Bir				
Director		316-78-1544 1 M 2XF 5 Yrs.	ns Days Hours Will	08/2		untry) Mary and			
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
	5	Maryland Baltimore		;	1 Yes 2 No				
Maryla 28a-f	Director		p Code	10	g. Citizen of What Cour	ntry?			
ith the Maryland 23a or 28a-f show notified at once.	Ö	2524 Westwood Ave. 21	1216		U. S. A.				
eath wi	Funeral	1 Never Married 2 Married Armed Forces? If Yes, speci	lent of Hispanic Origin? ( Spirify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc.	can Indian, 8lack,			
fter de		3 Widowed 4 Divorced If Yes, Give Year	No specify:		Specify: B	lack			
nours a	To Be Completed by	during most of wo	Occupation (Give kind of vorking life, DO NOT use reti		16b. Kind of Business/I	ndustry			
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5-00 led with tygiene other t		17 Father's Name (First, Middle, Last)		(First, Middle, Ma	Unknow/ aiden Surname)				
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-1 she traumatic event, the Medical Examiner must be notified at once.		Robert McKinley Bullock	Alice	L. Roo	lgers				
ID 2. should and M. 7 is main matic c		19a. Informant's Name/Relationship (Tyob, Print)  19b. Mailing Address	s (Street and Number or F	Rural Route Numb	per, City or Town, State,	Zip Code)			
e, MC 1 and 2 sh Health an item 27	ł	Alice Simmon ( Mother 3807 Rei 20a. Method of Disposition (Name 20b. Place of Disposition (Name 20b. Place of Disposition)	sterstown Kd	. Saltin	20c. Location - City or	7/2/5 Town, State			
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours at ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin		1 8urial 2 Cremation 3 Removal from State crematory or other place	2	Listin	R. 14.	111 1			
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traur	ŀ	4 Donation 5 Other Specify: Metro Cremot  21. Signature of Funeral Service Licensee 22. Name and	Address of Facility	y Decele	C. Jones Funer	of Home PA			
		Jamil C. 4611 Par	k Heights Ave	Button	are Marylan				
Physician /Medical		23a. Part I. Enter the disease, or complications hat caused the death. Do not enter the mode failure. List only one cause on each line.	of dying, such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and			
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Cocaine intoxication  Due to (or as a consequence of):				Death			
	Ļ	Sequentially list conditions, b							
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c							
ted 1 Insit		events resulting in death) Last Due to (or as a consequence of):							
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W = 2 %		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spec		ncy	Month Da	ay Year			
Boy e death the atte	ΞL	1 Yes 2 No 9 Unknown							
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Division of Vital Records, P.O. Box 6 within 24 hours after death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attentic completely filled in by the funeral director, page 2 should be detached for use.	ed Legi	(Check only one) 1 Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	Ž	29b. Signature and title of certifier 29c	License number		29d. Date signed (Mont				
ok I		Woulente The Voil	O.C.M.E.		September 12, 20 	10			
Berg		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
Sta	te	31. Date filed (Month Day, Year) 32 Registrar's Signature SEP 15 2010							
Registr	ar	SET I DEVILO JAMES 15. APRILLE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2002 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day ROSCOE BENNETT September 8:25 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 8 1935 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Days Hours VIRGINIA Director 75 Yrs. 231-40-5927 Usual Residence of Decedent 28a-f show 10b. County te 10a. State 10c. City, Town or Location 10d. Inside City Limits rector ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No MARYLAND N/A BALTIMORE ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4602 LASALLE AVENUE 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 A Yes 2 No If Yes, Give 59/6/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK "natural", rryes, Give Year or Dates 58/64 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade CONSTRUCTION PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H is marked o ၉ WILLIE GORDON MARY BENNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra Barbara Bennett/Wife <u>4602 LaSalle Ave., Baltimore.</u> 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town. State cemetery, crematory or other place) 4 Dongtion 5 Other (Specify) METRO CREMATORY 09-16-10 BALTIMORE, MARYLAND 21. Signal of Funeral Service Liven ree 22. Name and Address of Facility
WILLIAM C BROWN
1206 W NORTH AV COMMUNITY FUNERAL HOME P.A. 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ complications disease or condition resulting in death) cf metastatic mesothelione ecic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). and -transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) **burial**attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by arten disease, Diabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of nours after death.

neral Director: After the filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier

24 hours a Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier MD 00076635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Put 6 Suite 4105 Baltimore, Mp 2/200 701 N Charles 31. Date filed (Month, Day, Year) **SEP 1 5 2010** 2. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

			For	State of Ma	ırylan	nd / Department of H	Health and N	lental Hy	/gier	ne	
_			State Registrar	Certificate of Death				Reg. No. 2010 28824			
	1. Decedent's Name (First, Middle, Last)  Physician/					2. Date of Death Month Day Year 3. Time of Death					
1	Medi	edical Legh, Jean, 1390an						09		13 30	
	Exami	ner	University Name (ir not institution, give	Street and number)	C-1	4b. City, Town, or	Location of Death	0	- 1	4c. County of Dea	
1	Funeral		5. Social Security Number 6. S	Sex 7. Age	(in yrs. la	ast birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	N/	
-	Director		214-40-1209	□M 2XJF	58	Yrs. Months Days	Hours Min.	(Month, Di	8.1	941 Wes	ountry)
-	ld now	١.	Usual Residence of Decedent  10a, State 10b, County		100 Cib	y, Town or Location				711_1	
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	leath items er mi	E	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S			cify Yes or No-		U.S.A	
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ξ	ours a	etec	3 Widowed 4 X Divorced	Year or Dates.						Specify: W	hite
7.	72 h an "n Medi	ם	(Specify only highest gr	ade completed)		16a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	ation <i>luring m</i> ost of workir	ng	16b.	Kind of Business	Industry
7,	withir giene er th		Elementary/Seconday (0-12)	College (1-4 or 5+)	)	Homemak	er			Own Hom	۵
2	filed tal Hy d oth	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maide		
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only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and due to the cause(s) and marked the time, date and place, and the time, date and p								(s) and manner as	stated.		
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	Stat Registra	<b>-</b>	31. Date filed <i>(Month, Daly, Year)</i> <b>SEP 15 2010</b>	2. Registrar's	Signatur	re barked				7	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Name (First, Middle, Last, 2 Date of Death 3. Time of Death Physician/ otema Medical Examiner institution, give street and number) City, Town, or Location of Death unty of Death timore **Funeral** ast birthday Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1. M 2 D F Months Hours Min Director 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Funeral 21215 filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give þ 1 Never Married 2 Married Black, White, Baltimore, Maryland 21215-0036 2 No Black 1 ☐ Yes 2 ☑ No "natural", 3 Divorced Completed Specify Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last 18 Mother's Name (First, Middle, Malden Surname, permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic events. 2 Town, State, Zip Code) City or Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 🗌 Donation 5 Other (Specify) 21. Signature uneral Service mo ass 10 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate shock Interval Between Onset and Death Immediate Qause (Final √Pııysiciaπ/ a. Meta disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): nenoi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death Month Day Year Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably page 2 should Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy I Director: After this certificate I d in by the funeral director, pag perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death Certificate: Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury Accident Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatyle and title of cer 29c License number 13 cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State

Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year August 28, 2010 5:00 PM M Patricia Eleanor Baker 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Prince Georges Bradford Oaks Nursing Home Clinton 8. Date of Birth (Month, Day, Apr 17, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Min. Months Days Hours 1 ☐ M 2 🖸 F Virginia 76 579-46-1235 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No Prince Georges Brandywine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20613 USA 16308 Brandywine Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rosa Neil Brumfield William Early Bragg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 16308 Brandywine Road Brandywine, MD Raymond Baker/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 Other (Specify) 21. Signature of Euneral Service State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)

Pnysician /Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

"netural", or Itams 23e or 28e-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Exercitment and the modified at

Baltimore, Maryland 21215-0036

with the Maryland

**Examiner** The law requires that the death certificate be executed burial-transit and as the l

attending physician certificate has this

Completed

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Medical

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physicien:

within 24 hours a To tha Funaral L

Examiner	Sequentially list conditions, it any, leading to immovable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown
by Ph	Part II. Other significant cor

d.
23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown
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Due to (or as a consequence

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3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year
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derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?									
BREST	1 □ Yes 2	10 3 Probably 4 □Unkno	knowr							
	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings availa prior to completion of cause of death? 1 ☐ Yes 2 ☐ No								
26. Place of Death (C	Check only one)									
3 DOA Other: rsing Home	5 ☐ Residence 6	Other (Specify)								

						24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner?	lospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA	ome 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Pes 2 N		d. Describe how injury	occurred				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
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9b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
) H	719431	9/8/10
Name and address of person who completed cause	of death (Item 23a) (Type, Print)	FT. Wholigo MD 20144
11. Date filed (Month, Day York) 32. Re	gistrar's Signature	

		/								
30 Name	and addre	ess of	person	who	completed	çause	of death	(Item	23а) (Туре,	Print
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10-07015 Andrea Belice Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Andrea Belice		State of Maryland / Department 1- For State Registrar  Certificate			lental Hyg	-	Reg. No.	2010	2882
Physicia Medical Examir		Decedent's Name (First, Middle,Last)	16	-E		Date of De Month Septemb	ath Day	Year 2010	3. Time of Death 1857 hrs
		Facility Name (if not institution, give street and number)     Memorial Hospital	4	b. City, Town, or Locati Easton	tion of Death			County of Dea	th
Funeral Director	ī	7, 1, 0, 0, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	) Yrs.		Under 24Hrs. lours Min.	8. Date of B		Fore	irthplace (State or ign country)
yland -f show any once.	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo  10c. Street and Number							10d. Inside City Limits 1 Yes 2 No
h the Mar 3a or 28a	l Direc	106 JONES STREET			7		Tug. Citize	en of What Co	-
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	11. Marital Status  1 Never Married 2 Married    12. Was Decedent Ever in U.S. Armed Forces?    1 Yes 2 No	Was If Ye	Decedent of Hispanic s, specify Cuban, Mexi	ican, Puerto Ri			White, etc.	rican Indian, Black,
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ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	17. Father's Name (First, Middle, Last)			other's Name (F	irst, Middle,	Maiden S	Surname)	
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Baltimore, M permit Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		1 Burial 2 Cremation 3 Removal from State crematory or 4 Donation 5 Other Specify:	2. Na	CREM.	9/15 acility J N	/2010 Zumrs	14	Ampste 1=HA	rnov Co
Physician /Medical Examiner		24a. Ranty Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive cardio				ERC espiratory an	rest, shoc	<u>めを</u> のらら k, or heart	Approximate Interval Between Onset and Death
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S, P.O. B uires that the d an signed by the	[হ	Partin. Other significant conditions contributing to death but not resulting in the	e un	derlying cause given in		1 Ye	s 2 🔲	No 3 Pro	the cause of death?  bably 4  Unknown
tal Records,	Completed					1 Yes	osy ormed?		utopsy findings available completion of cause of
of Vital I	: To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  1. Manner of Death  28a. Date of Injury  28b. Time of Section 1. Section 2. Section 2. Section 3. Section			Nursing H				er:
Division of Vital Records,  To the Hospital or Attending Physician: The law require within 24 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Certification:	1 X Natural 5 Pending (Month, Day,Year) 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  (Month, Day,Year)  (28e. Place of Injury - At home, farm, stress (Specify)	reet,	1 Yes 2 factory, office building,		f. Location ( or Town, S		d Number or Ri	ural Route Number, City
0 7 7 7	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ one)  2 Medical Examiner: On the basis of examination and/or investigand manner stated.		n, in my opinion, death	occurred at th		and place	e, and due to th	ne cause(s)
		29b. Signature and title of certifier  Coural Hallan		O.C.M.E.	ber			ember 13, 2	onth, Day,Year) 2010
Ø			st	reet, Baltimore, M	MD 21201				
Sta	l(÷	31. Date filed (Month, Day, Year) 32. Registrar's Signature							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 13, Nicholas A. Boemmel Physician/ 4:12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 11130 Bird River Grove Road White Marsh Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign last birthday) Funeral 7. Age (In yrs. Months July 9, 1943 1**X** M 2 □ F 67 Days Hours Min. Baltimore, MD 217-40-4097 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a, State with the Maryland Director Baltimore White Marsh MD 1 🗌 Yes 2 🔀 No 10f. Zip Code 21162 10g. Citizen of What Country? 10e. Street and Number 11130 Bird River Grove Road Funeral U.S.A. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates the Medical 16b. Kind of Business Industry
Fort Howard Veterans 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Mason Be led 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Nicholas Boemmel Regina MacDonald be other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Michelle Calligan/Daughte 1681 Cape May Road, Baltimore, MD 21221 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept. 17, Most Holy Redeemer Cemeter 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, Maryland 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death e ate Cause (Final HEONIC OBSTRUCTIVE FILMONARY DITEM Physician dis e or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the attending philosophers IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death in the past 12 months? Month Day Year Pregnant at time of death ed by the a 1 L Yes 2 L 9 D Unknown P.O. that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an page 2 s aw prior to completion of cause of death? performed? Yes 2 X No The 1 Yes 2 No certificate To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certification of the Funeral Director, After this certification by the funeral director, It 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🛱 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending work? 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e of certifier 29b. Signature and t 29d. Date signed (Month, Day, Year) 038635 -SA

Registrar
DHMH 17 Rev 7/2009

State

9600 NORTH 8T. RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HORE

AR

State of Maryland / Department of Health and Mental Hygiene 1 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Rowr SODTOMOGR 2:05AM PHANIE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** BALTIMORE BALTIMORE SILCARIST OWIER Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Min. Au(40nth, 25, Year) 952 MaryTand Hours 58 Yrs. 31-62-9319 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Director 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 X No Cockeysville Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA <u>13011 Jerome Jay Drive</u> 21030 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Regional Institute For Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Children & Adolescents Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Liberti Evelyn Joseph Raphel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13011 Jerome Jay Drive Cockeysville, Maryland 21030 Patrick L. Brown, Sr./Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 9/16/10 Calvary Cemetery 4 Donation 5 Other (Specify) Conshohocken, 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, mo Maryland 21204 1050 York Road Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STROMAL -ASTROIN TESTINAL disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or sels consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregpant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ signed by the atte in the past 12 month Month Day Year Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ -HROMBOSIS VO NOUS 1 Yes 2 No 3 Probably 4 Unknown Completed peen ( 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗌 No 1 Yes Yes funeral director, 25. Was case referred to dical Be 26. Place of Death (Check only one) examiner? HUSPICE 12 1 🗌 Yes 2 🖪 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) Residence 6 \( \text{Other} \) Other (Special Contents) 1 Inpatient 2 ER/Outpatient 3 IDOA eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5  $\square$  Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death conum-29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) Type. State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State 28830 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Phillips Bailey-Ergler September 2010 5:50 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Days Hours 3/971926 201-18-4609 84 Pennsylvania **Director** Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville Maryland 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 Walther Blvd Apt 2401 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Teacher permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eric Phillips Viola Hinkley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derek Bailey / Son 6417 Cataloge Road Fork, Maryland 21051 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hillton Serv. Corp. 9/14/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Complications Physician/ muta static ovarian cource mouth s disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the effection. the attending physician and hed for use as the burial-transil that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS pice 1 Tes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier D0070633 30. Name and address of person v mpleted cause of death (Item 23a) (Type, Print) tc 4105 701 Churies SEP 15 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 28831 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ONNIC Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days Hours Min 02/26/1923 Director 245-28-0813 Newberry. 87 Usual Residence of Decedent or 28a-f show e notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22 Turnbrook Court 21234 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) C&P Telephone Risk Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Edgar McConnell Eddie May Maw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3654 Easthampton Drive, Gastonia, NC 28056 Doug Wright/ son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 09/17/2010 Parkville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Inc. 1050 York Road Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition subarachnou Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Exam or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 1 ☐ Yes 2 € 9 ☐ Unknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Inpatient 2 KER/Outpatient 3 IDOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e. 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending Certifica neral Director: A 13-2010 2:00 f Investigation 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 22 Jurnbrack ( 4 Homicide determined Baltimore within 24 hours a

To the Funeral D

completed filled i the Hospital mD 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 State Registrar

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AMEND ITEM#20a-c, perFH, G907, 9/15/2010, ws
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 27, 2000 Lee Corbett 1:36 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville 4c. County of Death
Montgomery **Examiner** Casey House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 248-66-6675 7. Age (In vrs. last birthday) 8. Date of Birth 6. Sex 1 X M 2 ☐ F **Funeral** Days Hours Min 08-24-1942 68 South Carolina **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location Director 1 🗆 Yes 2 No NY Kings Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11223 2257 W. 11th St. #7c 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thomas Absalom Corbett Eleatha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2257 W. 11th St. #7c Brooklyn, NY 11223 Bertha Corbett/Sister Baltimore, 20b. Place of Disposition (Name of Riverdalen Grenatory 20a. Method of Disposition Riverdale, MD State Waldorf, MD 1 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Sen 22. Name and Address of Facility Ronald Taylor II FH 0583 Middle Port Ln. White Plains, Konak 23a. Part 1. Enter the disease, or complications that cauged the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Hemorrhagic Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Casey House 1 ☐ Yes 2 🕅 No Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 64 Other (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD057313 Aug. 31, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 Linden Ave. Baltimore, MD 21201 Mitul Dave 32. Registar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09<sup>Day</sup> Month 09 Physician/ 2010 5:00P M Joan Cromwell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N. Arlington Security Number 6. Sex Apt Age (In yrs. Baltimore 600 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X** Months Hours Country) Yrs Director 214-54-5188 08 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 No NA Baltimore MD 10e, Street and Number 10f. Zip Code 'natural", or items 23a or 10g. Citizen of What Country? Funeral North Arlington Ave Apt permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes X☐ No Black, White, etc. þ 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black Completed 3 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker 2th grade 2vrs <u>State of Marvland</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charlotte Frazier Charles R. Cromwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roslyn Cromwell-Niece Baltimore, Md 21211 3832 Greenspring Ave, injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date **X** Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Ponation 5 Other (Specify) Memorial Park 9/16/2010 Woodlawn, Md e of Funeral Service Licen any in 22. Name and Address of Facility

March F/H West 4300 Wabash Baltimore, Md 21215 Ave, art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ atheroscientic neart disease Medical resulting in death) Due to (or as a consequence of): Examiner diabetesivelitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Due blor as a consequence of): attending physician and for use as the burial-trar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death the Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed chronic obstructive pulmonary disease 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has build in the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a section of the country and a autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \square Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 1 5 Pending iniury 1. Natural Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director: /
completed filled in by the I

> State Registrar

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R. Richardson

1 5 2010

29b, Signature and title of certifier

only one)

Heights Ave

evardron, un

32. Registrar's Signatur

340 Park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year)

29c. License number

Bacha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - Month Physician 2010 William Richard Chelton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SQUARE HOSpital 9. Birthplace (State or Foreign Country) Centre er 24 Hrs. 8. Date of Birth Min. (Month, Day, Year) 5. Social Security Number ( 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Director 213-32-5709 10/12/1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be mainful at 1 ☐ Yes 2 X No Funeral Director MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11305 Charlund Drive 21087 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 Insurance Broker Insurance Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William O. Chelton Irma E. List 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11305 Charlund Drive - Kingsville, Maryland Barbara J. Chelton (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 09/16/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed PIR burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 No signed by the 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🗷 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1. malell, mp

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State State Registrar

DHMH 17 Rev 1/2001

NADIJ MALIK MD 9000 Franklin Square Drive BAL+, mara MD 2/237
31. Date filed (Month, Day, Year) 32. Begistrar's Signature Superior Superior Superior Signature Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of De Physician/ Medical 4a. Facility Name (if not institution, give street and you 4c. County of Death 4b. City, Toy or Location of Deat Examiner 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Funeral 229.46.2104 1 M 2 X F Months Hours Country) Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director Baltimore 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? Funeral USA E. Biddle Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black "natural", Completed 3 ₩Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) And Health Care Muses 2th grade Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type, Print) Barbara D. eserve Circle Apt. 204 Windson Mill, MD aughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Blackstone, VA '2010 Prospect Cemetery D9 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vallahn C. Treene Funeral Senties anclalistown MD/21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arm shock, or heart failure. List only one cause on each line. e and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list our ditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certifical completed filled in by the funeral director, it 25. Was case referre o medica Division of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) Natural 2 Accider 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Physician/ 00 010 Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** our If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Months Min. (Month, Day, Yrs. Director Usual Residence of Deceden 28a-f show 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 items 23a Funeral 6 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ٥ Completed by 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify. is marked other than "natural", 3 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or item 27 70 20a. Method of Disposition 20b. Place of Disposition (Name of City or Town, State permit. Page 1 a Department of I Important: If its of. 1 Burial 2 remation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) ure of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) -transit or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed Yes 2 page 2 prior to completion of cause of death? has certificate 1 Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one, Be examiner? Hospital Other: 1 🗌 Yes ၉ 5 Residence 6 Other (Specify 1  $\square$  Inpatient 2  $\square$ ER/Outpatient 3 DOA 4 \( \square\) Nursing Home after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,MO State

DHMH 17 Rev 7/2009

Registrar

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		Registrar  1. Decedent's Name (First, Middle,	Last)		Cer	unicate of L	Dealii	2. Date of Dea	neg, No.	3. Time of Death		
Physician/ Medical	_	Alice J. Cu	mmings					Septem	iber <sup>Day</sup> 10, 2	2010 3:20 Р. м		
Examiner		la. Facility Name (if not institution, the Lorien Mays Ch		er)		4b. City, Town, or <b>Timoni</b>	Location of Death UM		4c. County of Ba	Death 1timore		
Funeral Director	5	S. Social Security Number 216–24–3063	6. Sex 1 □ M 2 <b>XX</b> F	Age (In yrs. la	91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da April	th 27, 1919	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
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Z15-003  Z15-003  in 72 hours at her "natural"  e Medical Ext	2	15. Decedent (Specify only highes			(Give k	ent's Usual Occupa aind of work done of NOT use retired)	ation Juring most of work	ing	16b. Kind of Busi	ness Industry		
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, War, d 2 should alth and N n 27 is me er trauma	19a. Informant's Name/Relationship (Type, Print)  Mr. Robert Leonard/ son  19b. Mailing Address (Street and Number or Rura 105 Farview Court T:							al Route Numbe <b>imonium</b>	r, City or Town, Stat , Marylan	te, Zip Code) nd 21093		
baltimore, imarylan permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.	2	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 🖟 ☐ Other (Sp		ate c	emetery, cren	ace of Disposition (Name of metery, crematory or other place) September   20c. Location - City or Town, State   20c. Location - City or Town, Stat						
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cian: The cian: The ertificate ector, par		25. Was case referred to medical				26. Pla	ace of Death (Chec	perfo 1 \sum Yes k only one)	2 <b>X</b> No. 1 L	Yes 2 No		
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JIVISION OI al or Attending Pr s after death. al Director: After th ad in by the funeral Certificate:		3 Suicide 6 Could n 4 Homicide determin	28e. Place of	Injury - At ho etc. (Specify		eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
he Hospita in 24 hours he Funeral pleted filled		(Check 2 Medical Ex	Physician: To the bes aminer: On the basis Nurse Practioner: To	of examination	and/or invest	igation, in my opinic	n, death occurred a	t the time, date a	and place, and due to	the cause(s) and manner stated.		
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3	3	30. Name and address of person w	ho completed cause	of death (Item	23a) (Type, P	rint) (05, B	alhmoxe	, md	2120	4		
State Registrar	3	31. Date filed (/SEP 1520	110 Centre	istrar's Signa	re pa	KI						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 11:00 P.M Andre Joseph Capoen, Sr. September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours 1 🔀 M 2 🗆 F 84 April Day (Month 1926) Belgium 579-46-8207 **Director** Usual Residence of Decedent «how 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland notified at Director 28a-f Timonium 1 🗌 Yes 2 🔀 No Maryland Baltimore 10e. Street and Number 10f. Zip Code ō United States the Medical Examiner must be Funeral 21093 items 23a 1819 Vista Lane of America death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. ö 1 Never Married 2 Married 2 X No à Yes Baltimore, Maryland 21215-0036 white 1 Yes 2X No Specify If Yes, Give Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Environmental permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Science Environmental Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Julienne Schouteten Elie Louis Joseph Capoen SEPTEMBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11725 Englewood Drive LaPlata, Maryland 20646 Mr. Andre J. Capoen, Jr./son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September Evans Funeral Chapel – Bel Air 1 
Burial 2 
Cremation 3 
Removal from State |Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10, 2010 of Juneral Service Licens Peaceful Afternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part . Enter the disease, or complications that of shock, or heart failure. List only one cause on a e, or complications that caused the death. Do not enter the mode of dwing, such as cardiac or respiratory arrest, List only one cause on path line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1051 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Þ JOSEPH 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law this certificate has ral director, page 2: autopsy death? 2**X** No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending M Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

2300 DULANEY VALLEY ROAD

TIMONIUM

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signat

ERNESTINE WRIGHT,

31. Date filed (MS)

200

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death oMonth 9 06 2010 9:55a. Warfield Marvin Davis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville Commons Catonsville If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 02 (Month, Day, Months Hours Min. 1 M 2 - F 81 217-24-7938 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4736 Wakefield Road Apt 202 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2X Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Senior Citizens Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade na Security Apartments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Warfield Christopher Davis</u> Hattie Henson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type, Print) Joyce Mae Davis-Wife 4736 Wakefield Road Apt 202, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 9/17/2010 Owings Mills, Md Signature of Nuneral Service Licensee 2. Name and Address of Facility
March F/H West 4300 Wabash Ave. Baltimore, 21215 Part 1. Enter the disease, or conections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final resulting in death) Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on Due to (or as a consequence of): yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify)

Physician/ Medical Examiner

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injury

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

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**Examiner** 

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho

Baltimore, Maryland 21215-0036

use as the burial-transi signed by the attending physician and Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Examine Physician/Medical þ Completed Be ြို Certificate:

After this certificate has been

within 24 hours after deatl To the Funeral Director:

Medical

that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 Yes 2 9 Unknown

9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? Hospital: 1 Tes 2 100 27. Manner of Death 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation

6 Could not be

determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

Other: 4 Wursing Home 5 - Residence 6 - Other (Specify) 28c. Injury at work?
1 Yes 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,

City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

and address of person who completed cause of death (Item 23a) (Type, Print)

36942

reduick Rd. Cotory is le

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State

29b. Sign

32. Registra 's Signature

Registrar DHMH 17 Rev 7/2009

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	Physicia		1. Decedent's Name (First, Middle, Last)  Valentina Drinkard	2. Date of Death Month Day Year OB 16 10 8:25AM
	/Medic Examin Funeral Director	-	4a. Facility Name (If not institution, give street and number)  Cotton Manor 3330 Wilkens Ave Buttimore  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Months Days Hours  1. Age (In yrs. last birthday)  Months Days Hours	of Death 4c. County of Death  MD. 21229 Baltimore City
ele:	D D	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  BALT, MORE	10d. Inside City Limits 1 17 fes 2 □ No
<b>'</b> 0	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menth Hygene. If Health and Menth Hygene. Item 27 is marked ther than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 1 Yes, specify Cuban, Mexica	n, Puerto Rican, etc.) Black, White, etc.
21215-0036	within 72 hours a iene. than "natural", o the Medical Exarr	Completed by		16b. Kind of Business/Industry
Maryland 2	2 should be filed and Mental Hygi is marked other aumatic event, i	To Be Co	17. Father's Name (First, Middle, Last)  CHARLES ALBRECHT  18. Meth	er's Name (First, Middle, Maiden Surname)  MARIE WELLS er or Rural Route Number, City or Town, State, Zip Code)
Baltimore, Ma	m O b	3	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ANE CLEN BURNIE  A Date 19 20c. Location - City or Town, State  M 200 (CLEN) POUR AND
Baltir	permit. Page Department Important: If any injury o		21. Signature of uneral Service Licensee  22. Name and Address of Facility  23. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as	4.2829 HURSONST, 2/21
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	s cardiac or respiratory arrest, Approximate Interval Between Onset and Death
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Division or V	ending Physath. or: After this he funeral dii	Certification: To E	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4	ursing Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred  No  28f. Location (Street and Number or Rural Route Number, City or Town, State)
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	To Com	2	29b. Signature and title of certifier  29c. License number  29c. License number  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29d. Date signed (Month, Day, Year)  8/16/15  Fenyllod 2122
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ferrysol 2122)
	Regist	ar	SEP 15 2010 Ceine B. Sail	

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./		5220 York Road Apt 3F				Baltimo		Hillaria O	Aller In Date of	Birth(MM/DD/YYYY	To pien	pologo (Stato or
Funeral Director		1	5. Sex 7	. Age (In yrs. last		If Under Months	Days	If Under 2- Hours	Min.	31 <b>,</b> 1952	Foreign	
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of Hear Ir		<ul><li>20a. Method of Disposition</li><li>1 Burial 2 Cremation</li></ul>	3 Removal from		ace of Disposi ematory or oth		of ceme	etery,	Date	20c. Location -	City or	Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iten		4 Donation 5 X Other Special Signature of Funeral Service I	ecify: in stal	/	22 N	ame and A	ddress o	of Facility	1.65	F 17 D 16	•	Charach
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of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate I After this certificate has been signed by the attending physimenal director, page 2 should be detached for use as the bring the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the stre	Physician/Me	hammand tupongal framework	9 Unknov						Loo- Di	d tobacco use contri	ib. do to	the equal of death?
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O.C.M.E. September 10, 2010											010	
-		30. Name and address of person Jack Titus MD. Dep	ho completed cause uty Chief Medica		<sup>(3a)</sup> 111 Pen	n Street	. Balti	more. MI	D 21201			
	tate	31. Date filed (Month, Day, Year)	37 Reg	istrar's Signature				,			-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 Day Physician/ Richard Lee Dahlberg Sr. ept 2010 3:30p <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Westminster Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F 02/971926 Director 84 504-16-5352 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 🗙 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 St. Mark Way Apt. 404 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. P. Completed by 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 947-1950 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Engineer</u> Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ပ Paul Dahlberg Minnie Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Richard Dahlberg Jr.-Son 7704 Ivy Oak Dr. Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/17/2010 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/16/10Crestlawn Mem Marriottsville 21. Signature of Foreral Service Licensee 22. Name and Address of FacilityFletcher Funeral Home Ε. Main Street Westminster, MD 21157 23a. Part 1. Inter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, then t failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to jor as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy Yes Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Other: 2 No 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Accident Suicide Investigation 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed

SEP 1 5 2010

cause of death (Item 23a) (Type, Print)

a

300

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month CME Day Physician/ Year 12:10 F M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Day, Days **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1 🗆 Yes 2 🕏 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White If Yes, Give Year or Dates Specify. Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) MIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee reral Chapel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only and cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ LABUR NONVIABLE PREMATURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X N death? 2 K No 1 🔲 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ၉ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 🔀 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛮 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Sign ure State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CLINTON GDDINS Month 2 O/ D 29 AM Seidember 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARBOR HOSPITAL BALTIMORE . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Yrs. Director 220-64-831 or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 No MI 10e. Street and Number 10g. Citizen of What Country? Funeral 3503 21215 U5A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Mack Year or Dates is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura) injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimas 9-18-2010 4 Donation 5 Other (Specify) 21. Sign were of Funeral Service Licensee ress of Facility Vaucha C. Greene Funeral Services 728 Li 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death LUNGCANCER Phusician/ ADVANCED disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** PNEUMONIA MULTILOBAR Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death To the Funeral Director; After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached Unknown g | Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 2  $\square$  No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier RES-000 Resident September 11,2010

Registrar
DHMH 17 Rev 7/2009

State

egistrar's Signatu

3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND, 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEENU SHEELA

31. Date filed (Month, Day,

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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). Bo the deat by the at ached for	<u>}</u>	Yes 2 1			9 Unknown							100- D: I	7		
P	2	art II. Other signi	ificant condi	ions co	ntributing to de	ath but not r	esulting in	the underly	ying cause o	given in Pa	ırt I.			No 3 Pr	to the cause of death?
Records,   The law requires fricate has been sig											•	24a. Wa			autopsy findings availabl
e law e e has t ge 2 sh												per	opsy formed? 2 🗸 1	death'	completion of cause of Yes 2 No
al Re nn: Th rtificat tor, pa		5. Was case refer	red to medica	1 7					26.Place	e of Death (	(Check onl		2 🖤 1	•	res 2 No
f Vita Physicia or this cer ral direct To Be	1	examiner? 1 ✓ Yes	2 No	Hos	oital: 1 Inpa	itient 2	ER/Outpa	tient 3	DOA	Other 4	Nursing H	lome 5	Resid	ence 6 🗸 Oth	ner: Scene
of ing Ph	2	7. Manner of Deat			28a. Date of I (Month, Da FOUND:	njury y,Year)	28b. Time FOUND	e of Injury		ry at Work	IPI:			ury occurred head with co	onnections to
Sion ttend death. ctor: y the f		1 Natural 2 Accident	5 Pen- Inve	ding stigation	Sep 12, 20	10	2245 hr	s		Yes 2	No he	lium tan	ks		
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Lospits t hours uners ly fille		4 Homicide			(Specify) N			occurred at	the time da	ate and nia	-			nd manner as st	
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the		Check only '		miner: Or	n the basis of e	xamination a								ace, and due to	
F S S S S S S S S S S S S S S S S S S S	2	9b. Signature and	title of certific		d manner state	u.		T	29c. Licens	se number			29d.	Date signed (N	fonth, Day, Year)
		( ex	1 119	X	A10	ML			O.C.I	M.E.			Se	otember 13,	2010
nv	3	0. Name and addr	VII.		4						0400:				
State	a 3	Carol Allan, 1. Date filed (Mon		sistant	Medical Ex	aminer		nn Stree	et, Baltim	ore, MD	21201				
Registra	Ÿ		SEP 1	201		un.		back	1						

DHMH 17 Rev 1/2001 OCME 2006

OCME

A factor ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Sep. 04,2010 Marsena Field 3:09 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George"s Hospital Center Prince Geroges <u>Cheverly</u> 8. Date of Birth (Month, Day, Ye Feb. 18, 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF 79 Hours New Jersey Director Feb. 1931 047-28-6041 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Completed by Funeral Director 1 🗌 Yes 2 🙀 No <u>Fairfax</u> Reston Virginia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20191 11700 Blue Smoke Trail Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Never Married 2 🌠 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Kathryn Elizabeth Kitchel Burgess John P. Kuhl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Field/Son Westmont Lane. Bowie. Md.Baltimore, 20b. Place of Disposition (Name of Morreguery, grentation) other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cremation Services 19/10/2010 Chantilly, Va. 20151 . Sign / u of Fuperal / rvice Licensee R. Downer. Name and Address of Facility Money & King Funeral Home, Inc. Gary CCO508 W. Maple Ave. Vienna. 171 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical e to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying REPLACEMENT TRANSAPICAL ADRTIC for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year ☐ Pregnant : ☐ Unknown Pregnant at time of death ☐ Yes ∠ ⊭ ☐ Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate has page 2 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 KER/Outpatient 3 I DOA 1 Tes မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifythg Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

15V

State Registrar 30. Name and address of per

KECHI

31. Date filed (Month, Day, Year) 32. Registr

FREDERICK

32. Registrar's Signature

12200

ANNAPOLIS

who completed cause of death (Item 23a) (Type, Print)

DKWARA

STE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 2011, 2010 Physician/ 6:36 рм Thomas Douglas Flemming Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 D F Days NoV I, Day 1926 Months 214-24-8318 83 Yrs. MaryTand Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8415 Bellona Lane, Apt 611 21204 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married filed within 72 hours after al Hygiene. If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify. WW II Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Railroad Clerk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad 2 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Flemming George Thomas Violet Sidley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori F. Peters-daughter 2518 Taylor Ave., Baltimore, MD permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem 1 Prk 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 9/17/10 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd.. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ PANCREATIC CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting, the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 25. Was case referred to medica completed filled in by the funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPTCE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5  $\square$  Pending work? Division 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

THOMAS FLEMMING

D.III

Registrar MH 17 Rev 7/2009

State

29b. Signature and title

**JACKIE** 

JONES,

30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

CRNP

2300 DULANEY VALLEY RD.

32. Register's Sign

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

10-06742	
Charles Gardner	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Gardner		State of Maryland / Department of Certificate of Registrar		/giene Reg	. No. 2010	2884							
Physicia Medical Examin		1. Decedent's Name (First, Middle, Last)  Chaples  GARd1	ne R	Date of Death     Month     September	Day Year 7, 2010	3. Time of Death 0558 hrs							
		4a. Facility Name (if not institution, give street and number) 5012 Walther Avenue	4b. City, Town, or Location of Death Baltimore		4c. County of Death								
Funeral Director	Į	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  249 - 68-5503 114 M 2 F 70 Yr	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	1 ~	(MM/DD/YYYY) 9. Bir Foreig Co								
ith the Maryland 23a or 28a-f show any molified at once.	I Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca Baly  10e. Street and Number 5010 Walther Ane	tion Li MORE 10f. Zip Code 21214	109	. Citizen of What Cour								
2 hours after death wi "natural", or items		1 Never Married 2 Married Armed Forces? If 1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: nt's Usual Occupation (Give kind of w nost of working life, DO NOT use retir	Rican, etc.) ork done	White, etc.  Specify: 5/	acican Indian, Black,  acic  ndustry  Service							
21; be fill hrtal F rked ent, 1	မ္က	MAThan GARDACA  19a. Informant's Name/Relationship (Type, Print) 515+65 [19b. Mailin	18.Mother's Name  MARY  ag Address (Street and Number or R  O 10 WAITHER	Eng L	er, City or Town, State	Zip Code) Ud. 21514							
Baltimore, permit. Pages lar Department of Hee Important: If Titel		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Si. a re of Funeral Service Lice.	sition (Name of cemetery, ther place)  ORCHNOSOFY 9/ Name and Address of Facility /// 639 W. Boead	pate 2 19/10 1/2P3 Me		Md. ahojei md.21213							
Physician /Medical Examiner		233 Part I. Exper the disease, or complications that caused the death. Do not enter the failure. List only on cause on each line.  Immediate Cause (Find disease or condition resulting in death)  Sequentially list conditions,  a. Dilated cardiovascul.  Due to (or as a consequence of):		respiratory mest	, shock, or heart	Approximate Interval Between Onset and Death							
executed an and al - transit	hysician/Medical Examin	by Physician/Medical	by Physician/Medical	by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
sicii					by Physician/M	by Physician/Medical	by Physician/Medical	edical	past 12 months?	11/1/10 TT  etal death 3 Ectopic pregnanther (Specify)	icy	23d. Date of delivery Month D	ay Year
P.O.								Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		prior to co	ably 4 Unknown opsy findings available ompletion of cause of	
Division of Vital Records, tal or Attending Physician: The law requirers after death, al Director: After this certificate has been si birector. After this certificate has been si led in by the fluent director, page 2 should be a feet of the fluent director, page 2 should be a feet of the fluent director, page 2 should be a feet of the fluent director.	To Be	25. Was case referred to medical examiner? 1 Ves 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Investigation	Injury 28c. Injury at Work?		sidence 6 🗹 Other:	Scene							
Division To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the	cal Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, and o	or Town, State	and manner as state	d.							
To the Hos within 24 h To the Fur completely	Med	one)  2 Medical Examiner: On the basis of examination and/or investiga and manner stated.  29b. Signature and title of certifier	29c. License number O.C.M.E.	2	d place, and due to the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of the general description of t	th, Day, Year)							
E.	Distri		Penn Street, Baltimore, MD	21201		9							
Sta Registra		31. Date filed (Month, Day, Year) P. Registrar's Signature.											
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OCME

10-06833 Alexander Davis	Ga	ither, Jr. State of M	int in Black Indelible lu aryland / Department of	f Health and Mental Hy			2885
		1- For State Registrar	Certificate or		Reg.	No.	
Physici Medical Exami		Decedent's Name (First, Middle,Last)  Alexander  D	avis Gaithe	1	2. Date of Death Month D September 7	av Year	3. Time of Death 1244 hrs
		4a. Facility Name (if not institution, give stree	and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Baltimore Washington Medical	Center	Glen Burnie		Anne Arundel	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs, last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth(	MM/DD/YYYY) 9. Birth Foreign	
Director		216-76-1319 <b>₹</b> ™ 2	F 49 Yrs		02/08		ntry) MD
<u>*</u>		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Locat	on.			10d. Inside City Limits
ow any				Off			1 Yes 2 No
ne Maryland or 28a-f show filed at once.	tor	MD Anne Arun  10e. Street and Number	del Crofton	10f 7in Code	140-	Oitimen of Miles Count	
Mar or 28a	Funeral Director			10f. Zip Code	10g.	Citizen of What Count	ry?
ith the 23a c	a D	1906 Encino Drive	/as Decedent Ever in U.S. 13. Wa	21114	-16. W N-	U.S.A.	
ath w items	ner		rmed Forces?	s Decedent of Hispanic Origin? ( Spe es, specify Cuban, Mexican, Puerto F		14. Race - Americ White, etc.	an Indian, Black,
ter de		3 Widowed 4 Divorced If Yes.	Yes 2 No	Yes 2X No specify:		Specify: Bla	ack
urs af tural'	d b	15. Decedent's Education (Specify only high	est grade completed) 16a. Deceden	t's Usual Dccupation (Give kind of we	ork done 16	Sb. Kind of Business/In	dustry
72 ho	etec		llege (1-4 or 5+) during m	ost of working life, DO NOT use retire	ed)	Heating a	and
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed	12th Grade	Truck	Driver		Air Condi	itioning
5-0 Iled w Hygie		17. Father's Name (First, Middle, Last)		18.Mother's Name (	First, Middle, Mai	den Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Dr. James E. Haun		Dr. Do	orothy :	B. Gaithe	317
imore, MD 21215-0036  Pages I and 2 should be fited within 72 hours after death with the Maryland and of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	욘	19a. Informant's Name/Relationship (Type, Pr		Address (Street and Number or Ru			
MD and 2 sho salth and em 27 is		Michelle L. Busch  20a Method of Disposition		Parkwood Ct., I		od, MD 20 Oc. Location - City or T	
Ore		1 Burial 2 Cremation 3 Rer	noval from State Joseph	erplace) 7 / 1		•	,
Baltimore, ME remit. Pages 1 and 2 s Department of Health a Important: If item 27 njury or other traum		4 Donation 5 Other Specify:				Baltimore	
Baltimore, MD 21 permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is mainjury or other traumatic ev		21. Sunature of Funeral Service Licensee	() Shan 21	seph H. Brown 40 N. Fulton 2	Jr. FU	neral Hom ltimore.N	ne PA MD 21217
Physician		23a. Part I. Enter the disease, or complication					Approximate Interval
/Medi_al	1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hy	pertensive atheros	sclerotic cardiov	ascular	disease	Between Onset and Death
Examiner			or as a consequence of):				
	J	Sequentially list conditions, b					
	<u>.</u>	cause. Enter Underlying Cause	or as a consequence of):				
-	xaminer	(Disease of injury that initiated	or as a consequence of):				V
executed an and al - transit	ш	d					
	lg:	X UNPENDED AME	DED, 27, per ME g909	11/17/10 TT			
Box 68760,  te death certificate be execute the attending physician and red for use as the burial - tran	sician/Medical	IF FEMALE: 23c.	If yes, outcome of pregnancy			23d. Date of delivery	
68 certif nding ise as	ian	past 12 months?	Prognant at time of death	al death 3 Ectopic pregnan	СУ	Month Da	y Year
30X death	ysic	1 Yes 2 No 9 Unknown 9	Unknown	er (Specify)			
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	y Phy	Part II. Other significant conditions contrib	uting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
signe signe	ğ ğ				1 Yes 2	2 No 3 Proba	bly 4 🗸 Unknown
rds requ	ete				24a. Was an autopsy		psy findings available moletion of cause of
eco he lav te has	Completed				performed	d? death?	2 No
Tiffica tor, pa	ŭ.	25. Was case referred to medical		26.Place of Death (Check or			
Vita ysicia his ce	To B	examiner?  1  Yes 2 No	1 Inpatient 2 V ER/Outpatient	3 DOA Other: Nursing	Home 5 Res	sidence 6 Other:	
of ng Ph	<u>'</u>	27. Manner of Death 28a	Date of Injury 28b. Time of In (Month, Day, Year)	jury 28c. Injury at Work? 2	8d. Describe how	injury occurred	
ion tendii eath. tor: ^	iğ.	1 X Natural 5 Pending 2 Accident Investigation	,	1 Yes 2 No			
VIS or At fitter d Direct	12		e. Place of Injury - At home, farm, stree	t, factory, office building, etc. 2	8f. Location (Street or Town, State	et and Number or Rura	Route Number, City
Dipital ours a seral I	Certification:	4 Homicide determined (S	pecify)	1	or rown, state		
Division of Vital Records, to the Hospital or Attending Physician: The law requiring 24 hours after death. To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should	g	(oncorronly	the best of my knowledge, death occurr				
To th withii To th	edical	2 0	basis of examination and/or investigati inner stated.	on, in my opinion, death occurred at t	ne ume, date and	place, and due to the	cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Peni

State 31. Date filed (Month, Day, Year)

SEP 1.5. 2010

29d. Date signed (Month, Day, Year)

September 8, 2010

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09<sup>month</sup> Physician/ 2ďľo ď9 4:40a. M Gadley Evadney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Frankford Nursing Home If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F (Month, Day, Year) Months Days Hours Min. **Director** 92 212-18-3916 09 3Ô Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am jointy or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Yes 2 No MD NA 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 21206 U.S.A. 5009 Frankford Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force þ 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) House Homemaker 8th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tapper Eric Tapper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 4108 Fairfax Road, Baltimore, Maryland <u> Carolyn Connor-Niece</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Memorial Park 9/13/2010 Woodlawn, 4 ☐ Donation 5 ☐ Other (Specify) King Sign Ture of Funeral Service License 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between lock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph\_sician/ ementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death g Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? performed? 2 0 No certificate Yes 2 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2. 00 ၉ ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural work? 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5102 September 10 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5901 north CHarles Street Baltimore Marylano 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 15 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1000 Gunn Medical Richard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth Funeral Min. Hours Mary land 216-30-0504 76 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 ☐ Yes 2 X No Glen Burnie Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral U.S.A. 21060 928 Blakistone Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ⚠ No Black, White, etc. 1 Never Married 2 Married þ 1 🗆 Yes 2 🖰 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Local 11 Pipe Insulator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Adele Cecil. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 928 Blakistone Road Glen Burnie, Maryland 21060 Margaret A. Gunn (Wife) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 09/17/2010 Glen Burnie, Maryland Glen Haven Mem. Pk. 21. Signature of Funeral Service Licensee McCarly-Polysifak Tyneral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Betweer weeks Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has page, performed Yes 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: injury work? Natural 5 Pending 2 No Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie on who completed cause of death (Item 23a) (Type, Print) Memorial Knothusky Unlow 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Zo ( o Physician/ 2.50 AM Medical Mary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARUMATE CUER BURNE AMNIE BAUTIMORE WASom wit on med of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. | Jan. 26, 1932 5. Social Security Number 6. Sex Sex 1 □ M 2 ₹ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Kentucky Director 218-26-5953 78 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Director 1 Yes 2 No Anne Arundel Millersville Maryland 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any finuy or other traumatic event, the Medical Examiner must be a suy finuy or other traumatic event, the Medical Examiner must be a Completed by Funeral 21108 U.S.A. 307 Dogwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 XNo
If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ♥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Salesclerk Department Store 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mattie Davidson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7965 Catherine Avenue Pasadena, Maryland 21122 Valerie B. Moreland (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Pk.: 09/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 22.Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Marvland . Signature of Fuperal Service Licenses 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slfock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final LUNG CANCOR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** MAHA TEARS Sequentially list conditions, if any, leading to immediate cause. Enter one anying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No ģ Month Year Day Pregnant at time of death g 🗌 Unknown 1 ☐ Yes ∠ L 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy perform death? 2 No 2 No 1 Yes Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death.

Director: After in by the furnitudes. Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 10059190 SEPT 13 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAZ GEORGE DR. ELEN BURNIE mp 2016

DHMH 17 Rev 7/2009

State Registrar 10-07006 Gerard Grant

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gerard Grant		851
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of (	
wedicai ≝xaminei	4a. Facility Name (if not institution, give street and number)  Ab. City, Town, or Location of Death  4c. County, of Death	irs
	Johns Hopkins Bayview Medical Center Baltimore N/A	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State 24Hrs.) 1 Months Days Hours Min. 07-06-1985 Foreign Country)	or or.
y u w	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside	City Limits
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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 33a or 28a-f sho natic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		
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Baltimo permit. Page Department o Important: injury or oth	21. Signature of Funeral Service Licenson  22. Name and Address of Facility 3405 W. Franklin St. 2  Nances M. Wallace F. S. Balton	1239
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- a	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
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e be buri		
D. Box 68760, the death certificate by the attending physic ched for use as the bur Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day	Year
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ires that the signed by I be detach	1 Yes 2 No 3 Probably 4 I	
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Vital I hysician: this certifi I director,	25. Was case referred to medical examiner? Hospital: 1   Inspital: 1   Inspital: 2   Inspital: 3   I	
- E . ~ E . ~	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury accurred	ehicle
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could not be Could n	nber, City
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To the Hos within 24 h To the Fun completely	(Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
Ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year, O.C.M.E.  September 12, 2010	1
0.1	30. Name and áddress of persón who completed cause of death (Item 23a)	
7	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  32. Revistra's Signature	
State Registrar		

DHMH 17 Rev 1/2001 OCME 2006

OOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month seora 09 2010 Medical 09 10:05p. 4a. Facility Name (if nainstitution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 307 8609 Wintergreen Ct. Unit Anne Arundel Odenton 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Months 1 M 2 Hours Min. **Director** 579-50-7815 70 39 DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the No. 20. 11. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Odenton 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8609 Wintergreen Ct. Unit 307 21113 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Black Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) sector<sub>g</sub> of Einancial 2th grade 5vrs+ Dept. of Treasury Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George William Henderson Sr. Bertha Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife <u>Mabanease</u> Henderson 8609 Wintergreen Ct, Unit 307, Md Odenton, Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial 9/16/2010 Suitland, Md ncoln 22. Name and Address of Facility
Marshall March
4308 Suitland, Signature of Funeral Service Licensee Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) month Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Dus to for as a consequence of, use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

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3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or

To the Funeral Direct
completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 Orleuns Street 12 MY Dra 2123 32. Registrar's State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Registrar	State of Mary		artment of H <i>tificate of D</i>		, ,	giene Reg. N2011	0 28856	
Physicia	n/	Decedent's Name (First, Middle, La.	•				2. Date of Dea	ath .	3. Time of Death	
Medic Examin	al	4a. Facility Name (if not institution, give		Lorrain	4b. City, Town, or	Location of Death	9	1 <sup>Day</sup> 20 <sup>Y</sup>		
		3302 Springda			Balti	more				
Funeral Director		5. Social Security Number 6. S 217–22–9283	Eex 7. Age (In	yrs. last birthday)  86 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da)	, Year)	Birthplace (State or Foreign Country)  V Δ	
ind show at	or	Usual Residence of Decedent  10a. State  10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits	
Maryla 28a-f s otified	Director	MD NA		Balti	imore				1 🔀 Yes 2 □ No	
ith the 23a or st be n		10e. Street and Number			10f. Zip Code	216		10g. Citizen of Wha		
leath w tems 2	Funeral	3302 Springdal 11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	✓ ✓ I  Was Decedent of His f Yes, specify Cuban	216 panic Origin? (Spe	ecify Yes or No-		American Indian,	
felial within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland ental Hygiene.  Red other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ✗ Widowed 4 ☐ Divorced	1 Yes 2 X No If Yes, Give Year or Dates.		Fes, specify Cuban		nican, etc.)		White, etc. Black	
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within giene.		Elementary/Seconday (0-12) 11th grade	College (1-4 or 5+) <b>na</b>		ONOT use retired)  urses Ai	de		Hospita		
should be filed within and Mental Hygiene. is marked other tha aumatic event, the haumatic event, the haumatic event, the head of the haumatic event, the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of the head of	To Be									
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4 4 3 3 5 ≤	١,	Mildred Fowlke			Northg					
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permit. Page Department Important: any injury o		21. Signature of Funeral Service Licen			. Name and Address	of Facility M	arch W	est F/H alto, MI		
		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	ne cause on each line						Approximate Interval Between	
Pnysician/ Medical	8 3	Immediate Cause (Final disease or condition resulting in death)			ATIC				Onset and Death	
Examiner	L.	Sequentially list conditions,	b. ADE	NOCAR	ZUNON	1A C	0201	<b>V</b>	~ YEARS	
ited d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co	insequence of):						
cate be executed physician and the burial-transit	edical Ex	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
tificate ng phys as the		IF FEMALE:	d.					1		
Attending Physician: The law requires that the death certific ard death certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of p 1  Live Birth 2  4  Pregnant at tim 9  Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year	
juires that the signed by uld be deta	þ	Part II. Other significant conditions of	NONE	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did to	\ /	te to the cause of death?	
The law rectate has bee page 2 sho	Completed						24a. Was a autop perfor	rmed2 prior deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sumbed{\subset}\) No	
sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:		Other	ce of Death (Check	. /			
ing Phys	ate: To	27. Manner of De Ih  1 ■ Natural 5 □ Pending	28a. Date of injury (Month, Day, Ye	2 ER/Outpatien 28b. Time of injury	28c. Injury work?	at		ence 6 Other (Some of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order	pecify)	
I or Attend affer death Director: /	Certificate:	2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined				′es 2 □ No	28f. Location (S City or Town		r Rural Route Number,	
To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 \( \sum \) Medical Exam	sician: To the best of my liner: On the basis of exami se Practioner: To the best	ination and/or invest	tigation, in my opinion	i, death occurred at	the time, date ar	nd place, and due to	the cause(s) and manner stated.	
To t with To t		29b. Signature and title of certifier	balimp	4	29c. License	number 5440	18	29d. Date signed (M	onth, Day, Year) 5-2010	
3		30. Name and address of person who	completed cause of death	ı (Item 23a) (Type, P	rint a BM	c Bo	iltimo	re, M	5-2010 D 21204	
Stat Registra		31. Date fil <b>SEP</b> th <b>1</b> 5 2010	32. Registrar's S	Signature Save						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 12:21 PM 2010 /Medical PMA 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) MORIRI Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 217-26 1 □ M 2 □ F -7962 Director MARYIAN Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. Count ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 740 and Mental Hygiene. Is marked other than "natural", or items 23a 16.5. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 \_\_Yes 2 \_\_VNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by BLRCK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) YURSIL HERLTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OSCAR JOHNSON NJRMIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra UBY L. R SISTER 20b. Place of Disposition (Name of pemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Lansdowne, 4 Donation 5 Dother (Specify) THE DERRICK C. JONES FH, P.A. 21. Signature of Funeral Service Licensee 4611 PARK HEIGHTS RXE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Inknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner One to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burlal-t Box 68760. Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 1 ∐Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of gertifie

06e

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

East University

29d. Date signed (Month. Dav. Year)

Patient Known as Karen Holt Baltimore Maryland 21215-0036

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.								
		•	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2								
	Physicia	n/	Decedent's Name (First, Middle, Last)	11-14			2. Date of Death 3. Time of Death				
	Medic Examin	al	4a. Facility Name (if not institution, give str	reet and number)	4b. City, Town, or Location of	Septent Septent	ver 13 2010 4c. County of Dea				
	/		Sinai Hospital		Baltimon	e city	/	VA			
~	Funeral Director		5. Social Security Number  3.77-70-1110  1 Usual Residence of Decedent	M 2 Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of B Min. (Month, D	lav. Yearl	irthplace (State or Foreign ountry)  Naryland			
	/aryland 8a-f shov tified at	Director	10a. State 10b. County	N/A 10c. City, Town or Lo	cation			10d. Inside City Limits 1			
	with the h s 23a or 2 ust be no	Funeral Di	10e. Street and Number 1348 Stock	ton Street	10f. Zip Code 2 1 2 1	7	10g. Citizen of What C	Country?			
5-0036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 9a.		11. Marital Status  1. Never Married 2  Married 3  Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Ori if Yes, specify Cuban, Mexicar I  Yes 2  No Specify:	i, Puerto Rican, etc.)	14. Race - Am Black, Wh Specify:				
21215-(	within 72 hor /giene. ner than "nat ner the Medica	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12),	completed) (Give	dent's Usual Occupation kind of work done during most O NOT use retired)	t of working	16b. Kind of Business	s Industry			
Maryland 2	should be filed on and Mental Hyg r is marked other raumatic event,	To Be	17. Father's Name (First, Middle, Last) Thomas	Smith		er's Name (First, Middle	, Maiden Surname)	DLT			
	and 2 shoul Health and N em 27 is ma ther trauma		19a. Informant's Name/Relationship (Type Terri Downey I	toiton - 151		ourne Rd	· Balto.	md. 21239			
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		20a. Method of Disposition  1 ★ Burial 2 ← Cremation 3 ← Re 4 ← Donation 5 ← Other (Specify)  21. Signature of Funeral Service Licent.	Wester	natory or other place)	9-18-2010	100011	r Town, State  NOC, MD.			
Ba	permit. Departn Importa any injt		Medeu m. C	Evelve 1	2. Name and Address of Facilit	vaelase t	N. Frank	, ynd, 21229			
	Physician/ Medical		23a. Part : Enter the disease, or complic shock, or heart dilure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not entro cause on each line.	er the mode of dying, such as	cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death			
	Examiner	<u>.</u>	Sequentially list conditions, b.	Pneumonia	_			2 days			
	e executed sian and urial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.		ular Disc	ase.	li .	10 years			
09/	cate be exe physician a s the burial-i					resulting in death) Last	Due to (or as a consequence of):				
. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physicial director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy  1	Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year			
ds, P.O.	uires that the signed by all the deta	þ	Part II. Other significant conditions cont	ributing to death but not resulting in the u	inderlying cause given in Part		tobacco use contribute to	o the cause of death?			
of Vital Records,	The law require cate has been si page 2 should	Completed				per		utopsy findings available completion of cause of es 2 No			
ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	spital:	Other:	th (Check only one)					
of V	ding Phys h. Afterthis fureraldi	te: To	27. Manner of Death  1 Natural 5 □ Pending	1 Impatient 2 ER/Outpatier  28a. Date of injury (Month, Day, Year)  28b. Time of injury			idence 6 Other (Spe how injury occurred	cify)			
sion	ttendir death. stor: Af / the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐		(Character and Marsel and D	I Day to Market			
Division	Hospital or Attending 24 hours a er death. Funeral Director: After sted filled i by the fure		4  Homicide determined	building, etc. (Specify)		(Street and Number or R wn, State)	urai Houte Number,				
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	To the within comp	_	29b. Signature and title of certifier		29c. License number		29d Date signed (Mon				
	(0V		30. Name and address of person who com  Ana B. Emilia  31. Date filed (Month Day Year)	npleted cause of death (Item 23a) (Type, F		of Balt	mone				
	Stat Registra	C	31. Date filed (Month, Day, Year)	32. Ingistras Signature	ald						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear Carter Hinton 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore University maryland Baltimore If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Year) 1 ₹ M 2 □ F Months Country) Maryland 2010 Sept 10, 43 infant Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 ☐ No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21223 328 N. Calhoun Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married black 1 ☐ Yes 2 🗓 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zarah Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) University of Maryland 22 S. Green Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5<u>₩Other(Specify</u>) in state 21. Signature Funeral Service Ucensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Ronald 8 Director 21201 Baltimore, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, otherst failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or conditi resulting in death) prematurit extreme Due to (or as a consequence of): Sequentially list conditions, if any Lating Lamb list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, it. Medical Espiries must be reclifted a

Baltimore, Maryland 21215-0036

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and burial-tran for use as the cate has been signed by the page 2 should be detached a

Division of Vital Records, P.O. Box 68760,

ģ Be

Examine Physician/Medical Completed Certification: To funeral completely filled in by the

	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1			te of delivery onth Day Ye <i>a</i> r		
Part II. Other significant conditi	ons contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use cont	tribute to the cause of death?  3 Probably 4 Unknown		
			- autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medica		26. Place of De	eath (Check only one)			
examiner? 1 ☐ Yes 2 No	Hospital: 1 Nanpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)		
27. Manner of Death 1 Matural 5 ☐ Pendir 2 ☐ Accident investi	28a. Date of Injury (Month, Day, Year) gation 28b	Time of Injury M 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occur			
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Stre				
29a. Certifier 1 Certifyii (Check only one)	Physician: To the best of my knowled Examiner: On the basis of examination and manner stated	ge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc	ice, and due to the cause(s) and mocurred at the time, date and place,	anner as stated. and due to the cause(s)		

29c. License number

1588988018

29d. Date signed (Month, Day, Year)

9-10-2010

State Registrar

Medical

31. Date filed (Month, Day,

aura

29b. Signature and title of certifier

32. Registrar's Signature back

MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

			For State	State of Marylar	•	artment o			Mental Hy	-	2010	2.0	860
			Registrar  1. Decedent's Name (First, Middle, Last)			lincale	oi De	alli	2. Date of De	Reg. N	102 U I U		e of Death
	Physici	an	Chase Hinto	\ <u>\</u>					Month		) 2010	0.31	18 AM
A.	/Medio		4a. Facility Name (If not institution, give			4b. City, Tov	vn, or Loc	cation of Deat			c. County of Death		
arth.	Examili	ler	University of Ma			Balt					saltimon		ty
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	ear If	Under 24 Hrs.	8. Date of Bi	rth	9 Birth		te or Foreign
	Director		infant	]M 2□ F	Yrs.	Months D	ays h	dours Min.	9-10.	- 20	10 Ma	1/10	ind
	pu >		Usual Residence of Decedent  10a. State 10b. County	100 0	ty, Town or Lo	cation						10d Incid	e City Limits
	aryla shov	5			**								res 2 □ No
	28a-f	Director	MD  10e. Street and Number	Ва	ltimore	10f. Zip Co	do			100.0	Citizen of What Cou	Λ	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show aumatic event, its Modical E-zer and the strained and aumatic event, its Modical E-zer and and a second a second and a second and a second a second and a second and a second a second and a second a s		328 N. Calhoun	Street		101. Zip 00		.223		rog. c	USA	ii iti y :	
	ns 23	Funeral		12. Was Decedent Ever in U	.S. 13. \	Was Decedent			specify Yes or N	0-	14. Race - Ameri	ican Indiar	1,
ယ	or iter		1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No	İ				pecify Yes or Note Rican, etc.)		Black, White,	etc.	
03	ral", c	Completed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2∏X	INO S	Specify:			Specify: b	lack	
2	72 h	etec	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual C kind of work a	ocupation	n ng most of wor	rking	16b.	Kind of Business/Ir	ndustry	
12	vithin sne. th <b>an</b>	ם	Elementary/Secondary (0-12)	College (1-4or 5+) infant	life. I	oo NOT use r infant					infant		
2	Hygie Hygie ther i	ပိ	infant  17. Father's Name (First, Middle, Last)	Illiant		unk		Mother's Nar	ne (First, Middle	. Maide			
an	d be f ental ced o	Be c	Tr. Fault S Hame (Finel, Inneals, Easy)						rah Mo		,		
Maryland 21215-0036	shoul nd Mi mari mari	٩	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	ng Address (S	treet and	Number or Re	ural Route Numl	ber, City	or Town, State, Zi	ip Code)	
2	1 and 2: Health a tem 27 is		University of Mar	yland	22	S. Gre	en S	treet I	Baltimor	e,	MD 21201	Ĺ	
ē,	sta of Hea item		20a. Method of Disposition	20b. I	Place of Dispo cemetery, cren	sition (Name o	of r place)	1	Date	20c.	Location - City or T	own, State	) )
altimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 🏋 Other (Specify)	emoval from State	,,	,	,,						
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Event and the profiled of once.		21. Signature of Foneral Service License Ronald	dade, Directo	r 23					7. E	Baltimore	Stre	et
			23a. Part 1. Enter the disease or compli	cations that caused the dear				MD 21 such as cardia		arrest,		Approxi	mate
	Physician		shock, heart failure. List only or Immediate Cause (Einal			1						Onset a	Between and Death
*	/Medical		disease or condition resulting in death)	Due to (or as a consec		matu	VIT	+					
	Examiner		Commentation line and the comment										
-	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):								
	ecute and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	uanaa af):								
8760,	ficate be executed physician and s the burial-transit	a E		Due to (or as a sortice)	quonice ory.								
687	ficate phys s the	edical	S- <b>X</b> -C										
Box	eath certific attending p	Ž	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn							23d. Date of deliv	very	
ň	000	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of		☐ Ectopic preg ☐ Other <i>(speci</i>					Month	Day	Year
О	at the by th tache	hys	9 🗆 Unknown	9 ☐ Unknown									
Ś	The law requires that the de ite has been signed by the age 2 should be detached	by F	Part II. Other significant conditions cor	tributing to death but not res	sulting in the u	nderlying caus	e given ir	n Part I.			o use contribute to		
Records,	equir een s rould	ted							1 🗆	Yes	2 No 3 Pro	obably 4	Unknown
ပ္	G (7) G (	Completed							24a. Was	psy	24b. Were aut prior to co	opsy fi <b>n</b> dir ompletion	ngs available of cause of
		ပ္ပ							perf 1 □ Yes	ormed?	death? No 1 ☐ Yes	2 🗆 No	
Vital	Physician: The Is r this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	lospital:				6. Place of Dea	ath (Check only	опе)			
	Phys r this ral dir	은	1 Yes 2 XNo	1 Inpatient 2	ER/Outpatier 28b. Time of				fome 5 ☐ Res		6 ☐ Other (Spec	eify)	
$\subseteq$	fte fte	tion	1 Natural 5 ☐ Pending	(Month, Day, Year)	Injury	M 280.	Injury at Work?	2 □ No	200. Describe	now in	jury occurred		
Division of	r Attending Phys ter death. irector: After this by the funeral dir	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory, of			28f. Location	(Street	and Number or Rui	ral Route l	Vumber,
É	al or s after al Dire	Certification: To	4 ☐ Homicide determined	building, etc. (Speci	ry)				City or To	wn, Sta	ate)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier 1 Certifying Physical (Check only one) 1 Medical Exami	sician: To the best of my knowner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at vestigation, in	the time, my opini	date and plac	e, and due to the urred at the time	e cause , date a	e(s) and manner as and place, and due	stated. to the cau	se(s)
	Fo the within Fo the comple	Me	29b. Signature and title of certifier			29c. L	icense nu	umber		29d. E	Date signed (Month	, Day, Yea	ır)
			Mer	hel mo		14	-80	CI V.RI	118	9	-10-20	010	
			30. Name and address of person who co	mpleted cause of death (Itel	m 23a) (Type,	Print)		7 0 0 0				_	
			Laura Merkel	MD 22	- S (	preen	e s	H L	Baltin	no	re M	0	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 5 2010	mpleted cause of death (Iter  MD 22  32 Registrar's Signa	1. As	Med							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, T - For State Registrar 28861 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Eileen F. Hynes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Days 1 M 2 WF July 5, 1922 88 081-22-8169 Director Usual Residence of Decedent 28a-f shov 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2 X No MD Baltimore Timonium 10 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 12261 Roundwood Road 21093 #1602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ori ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 'natural", Specify: Completed 3 X Widowed 4 Divorced white Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John McDonald Katherine Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Timothy J. Hynes, III 1007 Katy Lane; Towson, MD 21286 / son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 Coremation 3 - Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/15/2010 Parkwood Cemetery Baltimore, MD 21. Signature of Funeral Service License 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ransit pue that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 attending ph for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No as been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page death? certificate | Yes Division of Vital ours after death. eral Director; After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 X No Other: ၉ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 1 🔀 Natural 5 Pending injury 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioners To the best of my knowledge, de 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Eun Soon Im September 11. 2010 4:02 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** <sup>Year</sup> 1924 1 M 2XX Seoul, 217-74-4588 Months Days January January 86 Yrs Korea **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director Harford Abingdon Maryland 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g\_Citizen of What Country?
United States Funeral 21009 2909 Trellis Lane America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc.
Korean "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Yes, Giv 3

Widowed 4 □ Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2909 Trellis Lane Abingdon, Maryland 21009 Jennifer Jung Hee Dodson/dau. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September Dulaney valley place) 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 4 ☐ Donation ⊅ ☐ Other (Specify) Timonium, Maryland 14, 2010 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ 2 mentio disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify)  $\bigvee$ 1 ☐ Yes 2 ♣No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes Accident Suicide Investigation 6 Could not be ☐ Accident☐ Suicide☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 15 2010

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 10, 2010 6:28 a M Η. Johnson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min 14-14-1933 76 Director Washington, DC 578-80-4958 Usual Residence of Decedent f show 10b. County 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10d. Inside City Limits 1 XYes 2 No P.G. Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2215 Herring Creek Drive 20607 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedon Armed Forces?
1 ☐ Yes 2 😾 No Black, White, etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Legal Clerk IRS Be rt. Page 1 and 2 should co... artment of Health and Mental H. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. West Smith Daisy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Brown - Daughter 9120 Edmonson Court, Greenbelt, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Important: If it any injury or o 1 🗌 Burial 2 💆 Cremation 3 🗋 Removal from State Riverdale Pk Crematory 9-17-2010 Riverdale, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home . Signature of Funeral Service Lice 10583 Middleport Lane, White Plains, Maryland 20695 a. Part 1. Enter the disease sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Y 3 n ZV7 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 09-10-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20037 - DC

Registrar DHMH 17 Rev 7/2009

State

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32. Registrar's Sgnature

Bolello

Physici /Medi Examir

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If "Incident Error out to retiff of the one."

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	for State Registrar	State of Marylan		icate of L			Reg. No 2	010	28864
ın al	1. Decedent's Name (First, Middle, Last, DESTINY /MAN,		GLE			2. Date of De Month 09	ath Day 06	Year 2010	3. Time of Death 5 - 05 P M
er	4a. Facility Name (If not institution, give UNIVERSITY OF MARY	street and number)	CENTER 46		Location of Deat			nty of Death アパかの名	E CITY
	Infant	x 7. Age (In yrs. I		Under 1 Year onths Days 1	If Under 24 Hrs.   Hours   Min.   8   18	8. Date of Bir (Month, Da Sept 6	ay, Year)	Cour	place (State or Foreign htry) yland
	Usual Residence of Decedent  10a. State  10b. County	10c. City	y, Town or Location	n				1	0d. Inside City Limits
ctor	MD		Baltimor	e					1 Yes 2 □ No
Dire	10e. Street and Number 2613 W. Fairmont S	Street	1	Of, Zip Code	21223		10g. Citizen	of What Cour	ntry?
nera		12. Was Decedent Ever in U.S	S. 13. Was		ispanic Origin? (S n, Mexican, Puerl	pecify Yes or No		Race - Americ	can Indian,
Completed by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		s,specifyCuba ∕es 2 <u>X</u> No	n, Mexican, Puerl	to Rican, etc.)		Black, White, cify: b1	<sub>etc.</sub> .ack
leted	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Decedent' (Give kind	s Usual Occupa	ation Juring most of wor )	king	16b. Kind o	f Business/In	dustry
omp	Elementary/Secondary (0-12) infanr	College (1-4or 5+) infant	lite. DO r	infan			-i-	nfant	
Be C	17. Father's Name (First, Middle, Last)	Intant			18. Mother's Nar	ne (First, Middle,			
일					Sac	le Jones			
	19a. Informant's Name/Relationship (Ty				and Number or Ru		-		
	University of MD M  20a. Method of Disposition		ZZ S.		Street	Date		2120 on - City or To	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 MOther (Specify)	Removal from State	emetery, cremato	ry or other place	e)	Date	200. Localit	on - Oily or re	wii, Giale
	21. Signature of Funeral Service Licens Ronald S	age, Wirector			ss of Facility Omy Boar MD 212		Balti	more S	Street
ì	23a. Par 11. Enter the dis see, or or m. 1 shock, or heart failure. List only or	cations that caused the death	. Do not enter th	e mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	a. EXTREME P Due to (or as a consequ	PREMATU	RITY					Onset and Death
	resulting in death)	Due to (or as a consequ RESPIRATOR	ience of):	IPE					
ē	Sequentially list conditions, if env. leading to immediate	b. Due to (or as a consequ							
Ē	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	PULMONAR	•	ORRHA	GE				
Exa	resulting in death) Last	Due to (or as a consequ	,	115			-		
edical Examiner		d. INTRAVENT	RICHAR	HEM	PAMSISI	£.			
Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 / No 9   Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3 Ect	copic pregnancy ner (specify)	,	-	23d.	Date of delive	ery Day Year
by Pn	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the underl	ying cause give	en in Part I,		,		he cause of death?
eted							Yes 2 No		bably 4 Unknown
dmo						24a. Was autor perfo	osy ormed?	prior to co death?	psy findings available mpletion of cause of
ပိ	25. Was case referred to medical				26 Place of Dec	1 □ Yes ath (Check only o	2/Z/No	1 □Yes	2 🗆 No
o Be	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 ☑ Inpatient 2 ☐ i	ER/Outpatient 3	DOA Othe	ar.	lome 5 ☐ Resi		Other (Specia	(y)
tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe			
ertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, street, t	actory, office		28f. Location (S City or Tox	Street and Nu wn, State)	mber or Rura	al Route Number,
Medical Certification: To	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	siclan: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occition and/or investi	curred at the tin gation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and date and place	I manner as s ce, and due to	stated. the cause(s)
Me	29b. Signature and title of certifier  Shulk Moorth			29c. License	number 76 2		29d. Date sig		
	30. Name and address of person who co	U	23a) (Type, Print			HY, MD	VEIRE	106/21	ARUIAAIA
e	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure La d	17100	CAL CEN	ICK, BF	ici imo	CE, 11/1	THE CAIND
r	31. Date filed (Month), 137 2010	Service B.	Marke						

Sta Registr

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 Physician/ Donald Leroy Jackson, Sr. 3 1450 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital 5. Social Security Number 8. Date of Birth Nov 17, 1919 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 90 vrs If Under 1 Year If Under 24 Hrs. Sex 1XXM 2 □ F **Funeral** 217-07-7080 Days Months Hours Yrs Director Usual Residence of Deceden iral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Middle River Baltimore MD 1 Tes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 111 Covered Wagon Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. White 3 XWidowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Enterprise Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Electrician Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edna West Baker John Henry Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Lahey- Daughter 651 Route 3A, Bow, New Hampshire 03304 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park Sept 16,2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility Fivans Funeral Chapel and Cremation Services 8800 Harford Road, Parkville, Maryland 21234 Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stenosi disease or condition 42055 Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any leading to hamediate cause. Enter Underlying or as a consequence of) Cause (Disease or iinjury that initiated events Atheroscleotre Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a Id be detached f Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 N 1 🗌 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes မ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

neral Director: Af filled in by the fu 1 \sum Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) e Funeral Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wein 201 G Baltmore Universit Phwy MD 32. Registrar's Si State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar SETHI MD 1160 VARNUM ST.

32. Registrar's Signature

20017

SUITE#302 WASHINGTON.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.

HARMINDER

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental	Hygiene 1	
	70 10	
Contificate of Dooth		

		1 - State Ragistrar		artment of H rtificate of L	ealth and Mental Hy Death	Reg. No.
Physic /Med Exami	ical	1. Decedent's Name (First, Middle, Last)  Ronald Lee Kyle  4a. Facility Name (If not institution, give street and number)  516 Stone Rd.		4b. City, Town, or Westmi	Month Sept	Day Year
Funeral Director		214-76-5673 <sup>1™</sup> <sup>2□</sup> F	n yrs. last birthday) 64 Yrs.	Months Days	Hours Min. 8. Date of B (Month, D Sept.	orth year)  9. Birthplace (State or Foreign Country)  15,1945 Maryland
<b>BAITIMORE, IMARYIGATIC Z.I.Z.I.D-UUSO</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinat I was be inclined at once.	To Be Completed by Funeral Director	Maryland Carroll  10e. Street and Number  516 Stone Rd.  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last) Roy Mervin Kyle, Sr.  19a. Informant's Name/Relationship (Type, Print) Mary V. Zito — sister  20a. Method of Disposition  1 Name/Relation 3 Removal from State	19b. Maili 19b. Maili 516 20b. Place of Discomptory, cre Evergre	Was Decedent of Hi If Yes, specify Cuba  1 Yes 2 No  sedent's Usual Occup, a kind of work done of DO NOT use retired  Stone I Sostion (Name of ematory or other place een Mem.  2. Name and Address  2. Name and Address  2. Name and Address  2. Name and Address  2. Name and Address  2. Name and Address  2. Name and Address  3. 1158  2. Name and Address  3. 1158  3. 1158  3. 1158  3. 1158  3. 1158  3. 1158  3. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4. 1158  4	spanic Origin? (Specify Yes or No. Mexican, Puerto Rican, etc.)  Specify:  ation  18. Mother's Name (First, Middle Ione Everhal  and Number or Rural Route Num  Rd. Westminst  Boardens  Is of Facility Eckhardt	Specify: White  16b. Kind of Business/Industry Summer Enterprises of the ARC  e. Maiden Sumame)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit property.		23a. Part1. Enter the disease, or complications that cause if the shock, or heart failure. List only one cause on each me. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequence of):  onsequ	DEctopic pregnancy Other (specify) underlying cause giv  ant 3 DOA of 28c. Injur Wor M 1 ctreet, factory, office	an in Part I.  23e. Did  24a. We aut per  1	23d. Date of delivery  Month Day Year  I tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  as an copy formed?  2 No 1 Yes 2 No  yone)  sidence 6 ther (Specify)  sidence 6 ther (Specify)  as how injury occurred  (Street and Number or Rural Route Number, own, State)
		30. Name and address of person who impleted cause of deal DK FIAVIO KVU to 555	th (Item 23a) (Type	n. Print) Cent	on St. Westm	mater MD 21157

DHMH 17 Rev 1/2001

Registrar

Amend Item 5 Please Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible.

1 - State of Maryland / Department of Health and Mental Hygiene amend #8 Per FH G907 9/29/10 III of Death

Reg. No. 1 28868 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 09 Day 12 Marie Elizabeth Kahl 7.00 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death BALTIMORE SAMARITAN and. Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X** ☐ F Months Hours Min Oct. 10, 1914 95 Maryland **Director** Jsual Residence of Decede 28a-f show otified at 10b. County 10a. State 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2/ No Maryland Baltimore, MD Baltimore County 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 Baltimore 4548 Fitch Avenue USA KAHL MARIE E. PT#1025115930 MR#218367815 09/12/1D Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify: White Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ä (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Marie Place N/A Self Employeed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Winkler, Agnes Agnes Winkler Joseph Frank Brockmeyer RENDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10/10/1914 ( BHARAJ, NARI TEAM PURPLE 1760 Liberty Grove Road Shirley A. McCulloch Colora, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gardense of Faith other place) 1 X Burial 2 Cremation 3 Removal from State September 17, 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Depa Impo any ii Lassahn Funeral Home Dostfor 13532M 7401 Balair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ CARDIOGENIC

Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner YOCARDIAI Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying executed Cause (Disease or linjury that initiated events ORONARY and the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown page 2 should be detached for Month Day Year Pregnant at time of death the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 ACUTE RENAL PAILUR 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform hours after death. Ineral Director: After this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 🗆 No 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) MD RES OOU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAZTIMORE MD 21239 5601 LOCHRAYEN BLYD, CAROLINE D'SOUZA 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

			For	e of Maryland / Dep	artment of Health	and Menta	l Hygier	ne2010	28869
			= State Registrar	Ce	rtificate of Death		Reg. i		
	Physici	an	1. Decedent's Name (First, Middle, Last)	1.		Mo		Day Year	3. Time of Death
w.	/Medic	al	Rachel Lelia Kozlows  4a. Facility Name (If not institution, give street ar		4b. City, Town, or Location of			3, 2010 4c. County of Death	4:30 PM <sup>M</sup>
	Examin	er	307 Somerset Avenue	d namper)	Cambridge	or Death		Dorches	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)		24 Hrs. 8. Date	e of Birth		place (State or Foreign
	Director		217-01-0948 1 M 2 M	96 Yrs.	World's Days Flours	Mar	7, 19	14 Mar	y I and
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I-f sho	tor	MD Dorchester	Camb	ridge				1 ⊟Yes 2 <b>X</b> ⊡ No
	or 28e	)irec	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
	23a c	<b>Funeral Director</b>	307 Somerset Avenue		2161	.3		USA	
	er dez items	nue	Arme	Decedent Ever in U.S. 13. ed Forces?	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar	igin? (Specify Y <i>e</i> n, Puerto Rican, e	s or No- etc.)	14. Race - Ameri Black, White,	
5	Ir's aft	þ	If Yes	Yes 2∏ No s, Give or Dates:	1 ∐Yes 2MNo <i>Specify:</i>			Specify: wh:	ite
იაიია	2 hou	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b.	Kind of Business/Ir	ndustry
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5	ages 1 nt of F i if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	from State 20b. Place of Dispo cemetery, crei	esition (Name of matory or other place)	Date	20c.	Location - City or To	own, State
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	o the Hospital of Attend within 24 hours after death.  To the Funeral Director: / completely filled in by the f	Medical	(Check only 2 Medical Examiner: On	o the best of my knowledge, deat the basis of examination and/or in manner stated.	n occurred at the time, date an vestigation, in my opinion, dea	nd place, and due ath occurred at th	e to the cause e time, date a	e(s) and manner as and place, and due t	stated. to the cause(s)
F	vithir To th comp	Me	29b. Signature and title of certifier	1 21	29c. License number		29d. [	Date signed (Month,	Day, Year)
			Mary Unn,	N. Moore	1) D3171	66		9-7-10	1
			30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print)	3	00	Dorche	Sterlike
	Stat	e_	31. Date filed (Month, Pay Voshin)	32. Registrar's Signature		1 (	メアカア	D. 1VI D	21012
				And the second second					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DREMARIE Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Seasons Hopsice/Northwest Hospital Baltimore Randallstown 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Davs Hours Min. Mar 16, Year) 935 Germany 75 **Director** 219-50-2993 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must he matical and injury or other traumatic event, the Medical Examiner must he matical and any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2004 Alto Vista Avenue 21207 Germany Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 attendant mausoleums Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Albert Gustav Wolter Frieda Selma Erdman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seasons Hospice 5401 Old Court Road Randallstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signa ure of peral Service Licensee Rona T.J. S. Way 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part Approximate Interval Between shock or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed completed filled in by the funeral director, page 2 should be detached for use as the burial-trans the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural Accident injury 5 Pending 2 🗌 No Investigation Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2. Řegistrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 5:25 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CARROLL DOVE WESTMINSTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Country) 71 Director Yrs. Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland Director mo CARROLL 1 Yes 2 No KESVILLE 10e. Street and Numbe 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🔀 No Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HEROSPACE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS OOROTHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRADDOCK ROAD MAUGHTER WOODSINE MO Page 1 and 2 TROST 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1- Burial 2 Cremation 3 Removal from State MOON TOWNSITIP, PA 12010 SUPPLECTION CEMETERY 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ZUMBINN FITA MON CO YFESVILLERD ELDERS BURG-MO 21784 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ OVARIAN 9/14/2 disease or condition resulting in death) 1/20101 Medical Due to (or as a conseque re of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و ک Records, 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director. After this certified completed filled in by the funeral director, I To the Hospital or Attending Physician: 25. Was case referred to predical of Vital 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 🗌 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Division ☐ Accident Investigation 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 🗓 🍑 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Robert Rice 555 South Cur 31. Date filed (Month, Day, Year) State SEP 1 5 2010 Registrar

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lames Jae Lee		S 1- For State Registrar	tate of Maryla		artment of <i>rtificate of</i>		d Mental H		201 eg. No.	0 2887
Physicia Medical Examin	n/	Decedent's Name (First, Mide     James	J	ae	· -	Lee		2. Date of Dea Month Septembe	Day Year	3. Time of Death 1651 hrs
		4a. Facility Name (if not instituti 1 Discovery Place	on, give street and nu	mber)	-	lb. City, Town, or L Silver Spring		1	4c. County of I	
Funeral Director		5. Social Security Number 560-17-9933	6. Sex	7. Age (In yrs. 4	•	If Under 1 Year Months Days				9. Birthplace (State or oreign Country) C.A.
aryland 8a-f show any at once.		Usual Residence of Decedent  10a. State 10b County			, Town or Locati				<u> </u>	10d. Inside City Limits 1 Yes 2 YNo
e Marylan or 28a-f sl	Director	10e. Street and Number	ges Co.	] 5	TIVEL	Spring		1	0g. Citizen of What	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Funeral D		12. Was Dec Armed Fo 1 Yes	2 X No	If Yo	2090 s Decedent of Hisp es, specify Cuban,	panic Origin? (Sp Mexican, Puerto		White, e	
5 72 hours afte n "natural", al Examiner	죄	3 Widowed 4 Di 15. Decedent's Education (Spe Elementary/Secondary (0-12)		le completed)	16a. Decedent	Yes 2 X No 's Usual Occupation ost of working life.	on (Give kind of v		Specify: 1	Asian ess/Industry
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MD 2121 nd 2 should be fi th and Mental m 27 is marked aumatic event,		Kwan Lee 19a. Informant's Name/Relation		or)	7.9	Address (Street		Rural Route Num	nber, City or Town, S	State, Zip Code 3 8 0 5 2 dmond , Wash .
Baltimore, MC permit. Pages I and 2 si Department of Health an Important: If item 27 in		Circisty Leon  20a. Method of Disposition  1 Burial 2 Crematio  4 Donation 5 Other S	n 3 Removal fro	om State JO	Place of Disposi	tion (Name of cemer Place) h F/	etery,	Date	20c. Location - Ci	ty or Town, State
Baltimo permit. Page Department c Important: injury or ott		21. Signature of Funeral Service	Licensee  // U/	illian	2 <del>3</del> 8	sephorns 40 N.Fu	of Brown alton A	Jr. F ve.,Ba	Uneral   .ltimore	Home PA ,MD 21217
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To the Ho within 24 To the Fu completely	edica	one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination ar		on, in my opinion, o	death occurred a		and place, and due t	o the cause(s)
		29b. Signature and title of certific	talle	ea		29c. License O.C.M			September 2,	
		30. Name and address of person Carol Allan, MD As	sistant Medical E	xaminer	111 Penn S	treet, Baltimor	re, MD 21201	1		
Sta Registra		SEP 15 2010 (Par)	Server 32. Reg	gistra's Signatu	re Kal					

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	uneral irector	Г	5. Social Security Number 021–38–7092	6. Sex	- V /		ast birthday) Yrs.	If Unde Months		If Under 24 Hr Hours Mir		rth av. Year 1 14	,1930 g.	Birthpla Country	ace (State or Foreign <sup>y)</sup> <b>Haiti</b>
pu	show	 	Usual Residence of Decedent 10a. State 10b. Coun	ity		10c. Cit	ty, Town or Lo	cation						10	d. Inside City Limits
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baltimore, permit. Page 1 and	Department of reall and went Important: If item 27 is marked any injury or other traumatic even		21. Signature of Funeral Service		1					of Eacility L. Homes		ALL	outus, Ma	цута	пи
<b>u</b> ac	) <u> </u>		23a. Part 1. Enter the disease,	or complicat		and the deet	55	555 'Iw	<u>in Knol</u>	Lls Road	<u>Columbi</u>		ryland 2		
~ Phy	sician/		shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one ca	use on each l	ine.	i. Do not ente		e or dying, s		Marketon or Secure	rest,			Approximate nterval Between Onset and Death
	ledical aminer		resulting in death)	<b>a</b>	Due to (or a	is a consequ	uence of):	5111	ac p	P   W (V YY)	oud			100	ne year _
		Jer	Sequentially list conditions,	b	Due to for s	is dicunsequ	Jehre of:					_		+	
), pet	ansit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	<b>5</b>	,		,								
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Sate b	physic the b	edic		d										+	
certific	ending use as		IF FEMALE: 23b. Was decedent pregnant		If yes, outcom			le					23d. Date of o	deliver	
the death of	To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		1 ☐ Live Birti 4 ☐ Pregnan 9 ☐ Unknow	t at time of o	ul death 3 ∟ death 5 □	Other (sp					Month		ay <b>Ye</b> ar
es that	igned be det	by F	Part II. Other significant condit				ulting in the ur	nderlying o	ause given	in Part I.					cause of death?
aw requires	peen s	etec					1	- \							bly 4 Unknown
ne law	te has age 2 s	Completed by	Bronchiect	Q>15	uith	mu(o	us pli	1991	ng		24a. Was auto perfo	psy ormed?	prior to death	o comp	y findings available bletion of cause of
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tending Fleath.	or: After the funera	Certificate:	27. Manner of Death  1 🔀 Natural 5 🗌 Pend 2 🔲 Accident Inves 3 🗍 Suicide 6 🗍 Could	ding stigation	28a. Date of in (Month, E	ijury Day, Year)	28b. Time of injury	M 2	Bc. Injury at work? 1 ☐ Yes	s 2 🗆 No	28d. Describe h	now inju	y occurred		
talor At	al <b>Direc</b> led in by			mined 2		njury - At ho etc. <i>(Specify)</i>	me, farm, stre )	et, factory	, office		28f. Location (5 City or Tov			Rural Ro	oute Number,
the Hosp in 24 hou	the Funer	Medical	(Check 2 Medical	Examiner: 0	On the basis of	examination	and/or investi	igation, in r	ny opinion, o	death occurred	and due to the ca at the time, date a ace, and due to th	and place	e, and due to the	e cause	e(s) and manner stated
o tit	<b>5</b> 00		29b. Signature and title of certific		_h _a				License nu		3		te signed (Mor		•
			30. Name and address of persor	n who compl	eted cause of	death (Item	23a) (Type. Pr	rint)	000	3656	7	07	-09-	201	0
	Uj		Deborah Beld	nis St	t. Agnes	Hospi	Tal 90	o Ca	ton A	renue	Baltino	re 1	10		
F	Stat Registra	-	31. Date filed (Month, Day, Year)		32. Re (s	er's Signat	ure .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-28874 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9 Year 125 AM a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sulcesmil On 0 0 8. Date of Birth vrs. last birthday **Funeral** 9. Birthplace (State or Foreign -40-215 Months Min Country) Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 Ne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30 200 15 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Specify Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) econday/(0-12) Elementary/S should be filed within if Health and Mental Hygiene. item 27 is marked other tha str worke 11 Clar Be 17. Father's Name (First, Middle, Last) A Name (First, Middle, Maiden Surna ပ a R 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is 50 salto 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)  $2 \mathbf{Z}$ injury or Cremation 3 Removal from State ation 5 Other (Specify) ure of Funeral Service License 22. Name and Address of Famility 05 any Ю. he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art 1. Enter Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a cons vence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month ☐ Pregna... ☐ Unknown signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has I autopsy performed death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De 11 Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending s after death Accident 1 \sum Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c, License numbe

State Registrar 30. Name and address of person

31. Date filed Month, Day, Year,

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mag Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 213-20-0400 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ¥ Yes 2 ☐ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 usA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 2 X Maryland 21215-0036 1 Yes If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Business Industry sind of work done during mo DNOT use retired) SSEMBLE nday (0-12) College (1-4 or 5+) Be ather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 oset ant's Name/Relationship (Typ uruson Baltimore, 20a. Method of Disposition 20b. Place of Disposition cemetery cremators 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sin aure of Funeral Service Licensee Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 2 🔏 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🗶 No Other: ၉ 1 Yes 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5  $\square$  Pending Accident Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 300 MARGARET VIRGINIA LONG 8 2010 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | JULY 7, 1946 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F MARYLAND 218-46-7224 Director 64 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the "Modical Examinar must be notified at Director 1 ☐ Yes 2 X No MD HARFORD **ABERDEEN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 434 HOLLY DRIVE 21001 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any Injury or other traumatic event, the Modit once. Elementary/Secondary (0-12) College (1-4or 5+) 12 DOMESTIC HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JAMES HENRY VENKER, JR. DOLORES CHARLOTTE GANNZZERMILLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM J. LONG, SR. / HUSBAND 434 HOLLY DRIVE, ABERDEEN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARMEL CEMETERY 9/10/10 BALTIMORE, MARYLAND 21. Signature of Fundament Service Licensee 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 21,
700 S. CONKLING STREET, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hypercaphic

Due to (or as a consequence of): disease or condition resulting in death) respiratory /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or Injury Examiner Due to (unds a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial P.O. Box 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 2 □ No 1 ☐Yes 2 ☑No 1 □Yes After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29c. License number OR SANWAKE RESOGOO -8-2010

Registrar
DHMH 17 Rev 1/2001

Margarel

9000 FRANKLIN SQUEIC OR BOLTO Md 21237

address of person who completed cause of death (Item 23a) (Type, Print)

Sarwate

32. Registrar's Signature

Devadalla

31. Date filed (Month, Day, Year)

SEP 1 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 9, 2010 George Thomas Ludwig 7:15P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hart Heritage Assisted Living Harford Forest Hill 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Min. Hours 1 XX 2 🗆 Sept. 27, 1915 Missouri Director 307-18-6481 94 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland **Funeral Director** or 28a-f 1 Yes 2XXNo Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1915 Rock Spring Road and 2 should be filed within 72 hours after death with Health and Mental Hygiene. 21050 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or iter dical Examiner Black, White, etc. Completed by I 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seagrams Distillers <u>Executive Vice President</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 27 is marker George Ludwig Ima Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the once. Lynne Glennon / Daughter 1307 Beckett Court Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept. Date 11, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel 4 Donation 2010 Forest Hill, Maryland Bel Air 21. Signature of uneral Service Licensee Evans Funeral Chapel & Cremation Services-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Heart Failure Onset and Death Immediate Cause (Final "cr sistive Ph sician/ 421 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has, performed' Yes 2XX No 1 Tyes 2 No Division of Vital Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Assisted Hospital Other: 1 Tes 2 🔀 No ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 Inpatient 2 ER/Outpatient 3 DOA .endin.
...ter death.
al Director; After th.
'in by the fur-28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at I or Attending Patter death. 1 Natural 2 Accident 5 Pending M 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) Hospital 24 hours a the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 35889 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 615

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31. Date filed (Month, Day, SEP 15

FRAN

Year)

- W. MALPHAIL BELAIR MA 21014

## Director ms 23a or 28a-f shov must be notified at death with the Maryland items 23a a.m. Examiner 5 5-0036 within 72 hours after 1:15 "natural", the Medical Hygiene. 3altimore, Maryland 2121 other pernit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I SEPTEMBER 10,

For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 10, Physician/ 2010 1:15 Frederick L. Lurz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris 6. Sex If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 M 2 - F Months Davs Aug. 9 ay, Country)Maryland **1**910 215-07-5520 100 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location Director 1 Yes 2 No MD Baltimore Timonium 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21093 USA 2300 Dulaney Valley Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Hinkens Steamship Agency Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Marquerite Poske John Lurz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21401 633 Chase Street; Annapolis, Paul J. Lurz son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Method of Disposi Date 1X Burial 2 □ remation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/15/2010 Parkwood Cemetery Baltimore, MD 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTATE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence cry Cause (Disease or linjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No page 2 should be detached for Day Pregnant 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 X No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 X No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPTCE this 24 hours after death.
Funeral Director: After thi eted filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or icense number 29b. Signa re and title of certi 29d. Date signed (Month, Day, Year) Oh 2010 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) ERNESTINE WRIGHT, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) Registrar's Signatul State Registrar

Please Type or Print in Black Incelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

HMH 17 Rev 7/2009

FRED LURZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical : 54a.M. 2010 Eacility Name (if not institution, give street and number Examiner City, Town, or Location of Death 4c. County of Death HIMOVE 8. Date of Birth If Under 24 Hrs 9. Birthplace (State or Foreign If Under 1 Year **Funeral** Hours Director items 23a or 28a-f show 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director Yes 2 ☐ No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ρ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 Yes 1 Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) apores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura d/d/5 Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State TUMISON □ Donation 5 □ Other (Specify) uneral-Service Lice Signature of Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between neart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ Myocardin disease or condition UNKNOWN Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the attending physician and the for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year ned by the a detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy autop₀, performed っ ☑ certificate 2 Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 2 No Accident Investigation s after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certif dress of person who completed cause of death (Item 23a) (Type, Print) Baltimore Caton DV

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

1 5 2010

32. Registrar's

Kenneth Woodrow Maurice

10-06680 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

J <del>NK UNK</del>		- For State Registrar	St	ate of Maryla		epartment o C <i>ertificate o</i>		and N	/lental H		Reg. No.	201	0	28880
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		4a. Facility Name (if	not institutio	oodrow M n, give street and nu			4b. City, Town,		ation of Deat	Septemb		. County of	Death	
Funeral	4	2800 West P		Avenue 6. Sex	7. Age (In v	yrs. last birthday)	Baltimore		Under 24Hr	s. 8. Date of E	Birth (MM/	DD/YYYY	9. Birth	place (State or
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (F		Last)				18.M		e (First, Middle,				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. TO BE Commissed by Europeal Director		19a. Informant's Nam	ne/Relations		er				Number or	Rural Route Nu	ımber, Ci	ty or Town,		. ,
e, MD 1 and 2 sho Health and item 27 is	ł	20a. Method of Dispo	sition		2	Ob, Place of Dispos	ition (Name of	cemete	ry,	Date Date	20c. I	Location - C	ity or To	own. State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite njury or other tr		1 Burial 2 Donation 5	Other Sp		om State	crematory or ot Hollinger F Crematory	, inc.		×   147	tember , 2010	Pen	. Holly nsylvar	nia	
Balt permit Depart Impor		21. Sig were of Fund	eral Service	Licensee		<sup>22</sup> Pe	lame and Addr BOETUL A 325 YORK	iss of F Road	acijyes Timor	Funeral nium, Mar	and C yland	rematic 21093	n Œ	nter, P.A.
Physician // /Medical	1	2 . Par I. Enter the failure. List only												Approximate Interval Between Onset and Death
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760, icate be physici the bun	Dalk!	F FEMALE: 3b. Was decedent pi	regnant in th	23c. If yes, o	outcome of p	28a-f,pen	r ME gy				230	I. Date of de		
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D. Bo the dea by the a ched fo		1 Yes 2 No		ons contributing to		not resulting in the L	inderlying caus	e given	in Part I.	23e. Did	tobacco i	use contribu	te to th	e cause of death?
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the todicinal Certification: To Be Commisted by Divisional Management		2 Accident 3 Suicide	6 X Could	d not be	of Injury -	At home, farm, street ind: in we	et, factory, office	e buildir	ng, etc.	28f. Location	(Street ar	nd Number	or Rura	Route Number, City atapsco Ave
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Div To the Hospital o within 24 hours all To the Funeral D completely filled in	֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	one) 2 V N	ledical Exar	miner: On the basis of and manner st	of examination		ion, in my opini	ion, dea	th occurred		and pla	ce, and due	to the o	cause(s)
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:25 AM SEM Robert Mand 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAUTIMORE WASGING. TON AMPAE ARUNDEL 9 LE men 13 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day,
May 20, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 【 M 2 🗆 F °1925 Mary Land Director 217-12-9861 Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Marvland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8415 Bay Road 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 1949–1953 Year or Dates. Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: is marked other than "natural" 3 ¥ Widowed 4 □ Divorced White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene Physicial Therapist Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Oswa1d 01ga Kimburg Mand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 8415 Bay Road <u>Pasadena, Maryland</u> <u>Diana M. Mand</u> Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 9-17-2010 Baltimore Si nature of File cra Ser 22. Name and Address of Facility Ruck Towson Funeral Hom Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition CENEBROVASCUL ATS Medical resulting in death) Due to (or as a consequence of) Examiner RIAL TEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the burial-transil The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year certificate has been signed by the a rector, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsv death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician; To Be 25. Was case referred to medica filled in by the funeral director, 26. Place of Death (Check only one) 2√2 No Other: 1 \sum Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

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29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day 11 Physician/ 2010 9:50 Robert Walter Miller, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 3801 Canteberry Rd. #1010 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days July 23 1 🗶 M 2 🗆 F Months Hours 84 1926 Mary land Director 220-12-8929 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits within 72 hours after death with the Maryland Director Baltimore N/A 1 X Yes 2 No Md. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21218 3801 Canteberry Rd. #1010 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Manufacturing Elementary/Seconday (0-12) College (1-4 or 5+) the Co-Founder/ Vice President Filtration Systems traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Geotze Sadie Robert Walter Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 21 Brooklandville, Md. 21022 19a, Informant's Name/Relationship (Type, Print) Mr. Bruce C. Miller/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🗓 Burial 2 🗆 Cremation 3 🗀 Removal from State 9-15-10 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ervice Vicense 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) IVen mon Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Pregnant at time of death ed by the detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be detailed 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No 2 1 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes မြ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work 1 Tes 2 No 2 Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death position diet the time, date and place, and due to the caleso(s) and manner as arete 29b. Signature and title of certifier 29c. License number 2016 Jaill > Olmavier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

37

East

Samara

200

Warel

31. Date filed (Month, Day, Year)

CED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 12, 2010 Physician/ 5:10 Marie Marguerite Murphy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Villa Assumpta Baltimore If Under 1 Year I If Under 24 Hrs. 5, Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Sebt T. 1 🗆 M 2 👿 F 90 T920 Pennsylvania 196-42-2227 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Baltimore Stevenson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21153 1531 Greenspring Valley Road USA . Page 1 and 2 should be filed within 72 hours after death viment of Health and Mental Hygiene.
sant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Murphy Margaret Maguire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 Greenspring Valley Road; Stevenson, MD 21153 Sr. Patricia Hoeflich S.N.D. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o of Notre Dame 9/16/2010 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) isters 1050 York Road 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Par 1. Enter the disease, or complice in similar to aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death espiration Physician/ disease or condition resulting in death) Medical ue to 4 r as a consequenc ിവി Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical Box 68760 the as Se yes, outcome of pregnancy □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signage 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Anema Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. 2 Accident
3 Suicide
4 Homicide Accident Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certifier 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

SEP 15 2010

Drive

32. Registrar's Signature

Suite 312

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09 Month Physician/ Menikheim Doris Anna 20 10 7:59 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 1 □ M 2 🔀 F Director 218-18-7002 86 Yrs. 2/16/1923 Usual Residence of Decedent 23a or 28a-f shov 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 USA 2712 Parallel Path 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Lillian Hoffman August Schnieder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
716 Old St. Mary's Rd, Pylesville, MD, 21132 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Shirley Graumann / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Chester, 09/14/2010 Pennsylvania Ferris & Co. <sup>22. Name and Address of Facility</sup> Tarring—Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate Examiner Due to (or as a consequence of): if any leading to immediate cause. Enter Underlying Cause (Disease or linjury ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) \( \text{petient the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of th Certificate: To 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After t 1 Natural injury 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be

Division of Vital Records, P.O. of thours after death.

Funeral Director: A sleted filled in by the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the full within 2 To the

> State Registrar

4 Homicide

only one)

29b. Signature and title of certifier

determined

Com

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical James Barrie Nordberg eptember Day 1:59 PM 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Laurel Regional Hospital Prince George's Laure Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 26,1932 Days 1 M 2 X F Minnesota 476-30-7631 Director 78 Usual Residence of Decedent 28a-f shov 10a. State 10b. County artnent of Heath and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland 1 🗌 Yes 2 🙀 No Prince George Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12505 Ivory Pass 20708 Ű.S.A. 12. Was Decedent Ever In U.S. Armed Forces?

1 Yes 2 No 195
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 X Married and 2 should be filed within 72 hours after thealth and Mental Hygiene. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Analyst U.S Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor Emil Nordberg F. Elizabeth Barrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Nordberg (Wife) 12505 Ivory Pass Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ott 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 9-10-2010 Clarksville, Maryland f Fungral Service License Wilzke Funcial Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the elsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary disease or condition **≱** Medical resulting in death) Due to (or as a consequence of) \_\_\_\_\_\_ Examiner Cancer Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Pulmonary Disease by Physician/Medical Obstructive Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform Yes 2 N 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: 2 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director. Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Padmaja S. Udabi MD. D24174 Sep. 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Padmaju S. Udapi, MD 7350 Van DUS 7350 Van Dusen Road, Suite 380 Laurel, MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Nicholson ennis Medical cility Name (if not institution, give street and number) County of Death Examiner gomer 8. Date of Birth Month, Day, Social Security Number If Under 4 Hrs. **Funeral** 1 2 M 2 D F Yrs. Director avol Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No UP Omer 10f. In Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 Maryland 21215-0036 1 ☐ Yes 2 🕦 No Specify 3 Widowed 4 Divorced ack Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ٥ nformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City ხა Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Town, State Date 20c Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) cemetery, crematory 4 Donation Service License Si y atur of Funera 22. Name and Address of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Respiratory disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner 5/2 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit pneumonia and that initiated events resulting in death) Last Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical neck alis cess Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D67275

Registrar
DHMH 17 Rev 7/2009

mortsomer

30. Name and address of person who completed (aus) of death (Item 23a) (Type, Print)

32. Regiga

Natalie Branagan

31. Date filed (Month, Day, Year)

18101 PRINCE Philip Dr.

Hospitalest

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 12,2010 Chester Vytautas Noreika 3:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2821 Chenoak Avenue Parkville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Age (In yrs. last birthday) **Funeral** (Month, Day, 1 XM 2 □ F Months Days Hours Min. 215-30-7702 88 Kaunas, Lithuania **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore Parkville 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2821 Chenoak Avenue 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white "natural", 3 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) 5+ Baltimore Gas and Electric Elementary/Seconday (0-12) Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stasys Noreika Marjia Stucinskaite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Noreika-spouse 2821 Chenoak Avenue-Parkville, Maryland 21234 20a. Method of Disposition
1 ☐ Burial 2 🎦 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evanser/Fineralory of other place) and Cremation-Belair Sept.13,2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causi Interval Between Onset and Death Immediate Cause (Final Physician/ oronar disease or condition resulting in death) Medical o (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) Month Day sate has been signed by the a page 2 should be detached to gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Cate of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature ar title of certifier 2010 30. Name and address of person who completed ause of death (Itom 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mont

21236

Clau Road

7402

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13°,2010° ar SEPT. 11:45а м ANNA NISHCHUK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 2224 ESSEX STREET Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 🔀 F 77 0376971933 OKRAINE 215-30-8955 Director Usual Residence of Decedent works I 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 2224 ESSEX STREET 21231 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🄀 No Yes, Give Maryland 21215-0036 1 Tes 2 No Specify. 3 X Widowed 4 □ Divorced Specify: WHITE "natural" Completed Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE 12 DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MYKOLA WAWRYKIW PETRONELA PERESADA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROMAN NISHCHUK/ SON 2224 ESSEX STREET, BALTIMORE, MARYLAND 21231 Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ST. MICHAEL'S UKRAINIAN 9/15/10 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Fun Conce Licenses TILLY & ETLER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ FAILURE RENAL WEEK Medical resulting in death) Due to (or as a consequence of) Examiner WARLAN CANCER-ENK Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2× 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL 1  $\square$  Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe s after death.

Director: After this certificate! 1 ☐ Yes 2 ☐ No Yes 2 completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 A No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed dause of death (Item 23a) (Type, Print) CIRCUE BALTIMORE MD

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

10-06990 Donna O'Brien

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Donna O'Brien		1- For State	tate of Maryla		artment of ertificate of		nd Menta	al Hygiene	Reg. No.	010	28889	
Physic Medical Exam		Registrar  1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day September 11, 2010  3. Time of Death September 11, 2010  1253 hrs										
		4a. Facility Name (if not institut 355 Greenlow Road	ion, give street and nu	mber)		b. City, Town, o		Death	- 25	ounty of Dea timore Co		
Funeral Director		5. Social Security Number 219-68-8005	6. Sex	7. Age (In yrs. 51	last birthday) Yrs	If Under 1 Ye Months Da	_	1.0	Birth (MM/DD/ 26,195	Fore	Birthplace (State or sign Country) MD	
w any		Usual Residence of Decedent  10a, State 10b, County  MD Ba1	timore	1	onsville						10d. Inside City Limits 1 Yes 2 X No	
th the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number	LIMOTE	Cat		10f. Zip Code			10g. Citizen	of What Co		
ath with the litems 23a or	Funeral Di	355 Greenlow  11. Marital Status  1 Never Married 2 X	12. Was Deco			Decedent of H		? ( Specify Yes or Puerto Rican, etc.)			erican Indian, Black,	
ours after de atural", or	d by Fu	3 Widowed 4 D	ivorced If Yes, Give Year or Dates: ecify only highest grad			Yes 2 X N	ation (Give kir			ecify: W	White s/Industry	
036 vithin 72 h. ene. er than "n. Medical Ex	Completed	Elementary/Secondary (0-12	1	-4 or 5+)		ost of working lif	or		Rest	aurani	t/Bar	
1215-0 d be filed v fental Hygi larked othe	Be Co	17. Father's Name (First, Middl Donald Ray Some some some some some some some some s	cott		L10h Mailine	Address (Cha	The	Name (First, Middleresa Byresa Byresa Route M	ne	,	to To Code)	
and 2 shoul tealth and N tem 27 is m traumatic	욘	Daniel O'Bri		20b.	1264 Place of Dispos	Francis	Avenu	re; Halet	horpe,	MD 2		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiew with a startment of Health and Mental Hygiew and "unatural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Crematic 4 Dopation 5 Other 21. Sig ature of Funeral Service	Specify:	oni otate	22. N F1	Park Cen ame and Addres ineral H	s of Facility Iome of	9/16/201 ter ng Catonsv	ille,	n Selv Inc.	wao Nitz e	
Physician /Medical Examiner		23a. Part I. Ent of the disease, of failure. List only one caus Immediate Cause (Final diseasor condition resulting in death)	e on each line.	done Ir	Do not enter the toxicat	e mode of dying	, such as card		arrest, shock,	or heart	Approximate Interval Between Onset and Death	
Si & W	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	C.									
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To the I within 2 To the I complete	Medical	(Crieck brilly	aminer: On the basis o and manner st	f examination a			n, death occu		ite and place,	and due to t	I	
		30. Name and dress of person	Browl.	e of death (Item	n 23a)	0.0	M.E.		Septen	nber 12,	2010	
Ø		Melissa Brassell, MD  31. Date filed Month, Day Year	Assistant Med	dical Exami	ner 111 P	enn Street, I	Baltimore,	MD 21201				
Reais	tate	SEP 1 5 2010	Cenery 1	gis rar's Signat	LEG							

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State of Manyland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan	•	artment of F tificate of E			Reg. No. 201	0 28890
	Physicia	ın/	1. Decedent's Name (First, Middle, Las	·				2. Date of Dea	ath Day Year	
	Medic Examin	cal	MARSORIE  4a. Facility Name (i) not institution, give			4b. City, Town, or	Location of Deatl	09	4c. County of De	
		Ü		LIAL HOSPIT		Bi	Litimor	re		
	Funeral Director		241-64-0291	Pex 7. Age (In yrs. In	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h g. B y-Year) y-193/ S	irthplace (State or Foreign ountry) orth CotoLine
	and show	ō	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation		/		10d. Inside City Limits
	Maryl	irect	nd l	· ·	Salt	imore	-			1 Ves 2 No
	with the is 23a or	<b>Funeral Director</b>	10e. Street and Number , 2200 E Biddl	e steet A	et 106	10f. Zip Code	213		10g. Citizen of What C	country?
920	filed within 72 hours after death with the Maryland tal Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Vas Decedent of His f Yes, specify Cubar		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: BL	ite, etc.
215-0036	72 hou n "natu ledical	Completed	15. Decedent's E (Specify only highest gr		(Give I	lent's Usual Occupa	ntion uring most of wor	king	16b. Kind of Busines	s Industry
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and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)  Woses Wye	PS			18. Mother's Nar	me (First, Middle,	Maiden Surname)	
Maryland	2 should the and Me is and Me is and Me is and the traumatic		Moses Mye 19a. Informant's Name/Relationship (7)		19b. Mailir	g Address (Street a			r, City or Town, State, Z	(ip Code)
	1 and 2 s of Health item 27 i other tra		Ida Haptins 20a. Method of Disposition	>			dle 9		Balto. M	
Baltimore,	permit. Page 1: Department of I Important: If it any injury or of		1 Burjel 2 Cremation 3 C 4 Donation 5 Other (Specia	Removal from State		sition (Name of natory or other place	9/1	Date 6/10	20c. Location - City of	o. Nd
Bail	permit Depart Impor any in		21. Sign dury of Funeral Scrvice Livens	ulla		. Name and Addres $439~\mathcal{N}$ .		30	Balte. Y	12. 21213
	Ph_sician/		23a. Part 1. Enter the disease, or com shock, or heart failure List only o Immediate Cause (Final disease or condition	ne cause on each line.			, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Liver c Due to (or as a consequ		2.2				2 months
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ience of):					
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09/89	rtificate ing phy e as the	/Med	IF FEMALE:							
. Box c	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of pregna 1  Live Birth 2 Feta 4 Pregnant at time of c	Ideath 3	Ectopic pregnancy Other (specify)	/		23d, Date of d Month	elivery Day Year
ν. Ο	es that the signed by	by	Part II. Other significant conditions	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute t	to the cause of death?
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_	e Hospita 124 hours e Funeral	Medical	(Check 2 Medical Exami	sician: To the best of my knowle lner: On the basis of examination se Practioner: To the best of my	and/or invest	igation, in my opinior	n, death occurred a	at the time, date ar	nd place, and due to the	cause(s) and manner stated.
	To th withir To th comp		29b. Signature and title of certifier			29c. License			29d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who co			rint)			09, 10,	
			Gonzalo Pere			niversity	Parkw	ay, Balt	imore, Mr	21218
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per INF G908 10/08/10 Jh
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Vivian Claire Reininger 2:00 PM /Medical September 8.2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Relay 4945 Tulip Ave Baltimore

9. Birthplace (State or Foreign Country) 8. Date of Birth 1-10-1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 24 Hrs **Funeral** Days Min. 1**x**M 2□ F 77 Months Hours 460-48-5932 Philippines Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 ☐ No Director Relav 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 4945 Tulip Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Asian 1 ☐ Yes 2 🛣 No Specify: XX Widowed -4 M Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distillery Worker Liquor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Frank Schratz Pilar Lojo ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Reininger/ Son 4945 Tulip Ave., Baltimore, Maryland, 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Atlantic Crematory 9/10/2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (case monil disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed Were autopsy findings available prior to completion of cause of death? hasl autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate ha performed 1 ☐ Yes 2 No I∐Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 DA 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27, Mann f Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Catonsville, MD 21228 Maiden Year)-

DHMH 17 Rev 1/2001

State Registrar

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	Examin	er	4a. Facility Name (if not	t institution,	give street	and numbe	er)			4b. Cit	y, Town, or	Location	of Death		4	c. County	of Deatl	1	
			107 East 5. Social Security Numl	Ring	Facto 6. Sex			vre la	st birthday)		el Ai	r If Under	24 Hrs	8. Date of Bir	dh.	Harf		nplace (State or Foreign	_
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õ	fter d	by	1 Never Married		ied 1	med Force Yes 2 Yes, Give					2 🕅 No			Hican, etc.)			ck, White	, etc.	
ğ	ours a tural' al Ex	ted	3 🕅 Widowed 4		Ye	ear or Date	S.		10.0							Specify:	wn	ite	_
Ç.	72 hc n "na Aedic	Completed	(Specify	only highe	nt's Education st grade cor	npleted)			(Give		ual Occupa ork done d se retired)		t of worki	ing	16b.	Kind of B	usiness I	ndustry	
27245-0036	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at		Elementary/Second	lay (0-12)	Co	ollege (1-4	or 5+)			rdene	,				l N	Jurse	ry E	usiness	
	illed I oth	Be	17. Father's Name (Firs	t, Middle, L	ast)							18. Moth	er's Nam	e (First, Middle,	, Maidei	n Surname	9)		
Ха	ild be Menta narkec	₽ O	John Scha									Cla	ıra F	itch					_
Maryland	2 should Ith and Me 27 is marl r traumati	. 9	19a. Informant's Name					Ţ.	I	-				l Route Numbe	-				4
	e n		Shirley A 20a. Method of Disposi		parr	(daud			107 ace of Disp			Fact		Road -	_	_		21014 Town, State	-
no n	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		1 X Burial 2 □ 0	Cremation		val from St	ate	ce	metery, cre	matory or	other place	i i					•		
Baltımore,	permit. P Departme Importar any injur once.		21. Signature of Funera				1.	Gar	dens 2	OT Fa	nd Addres	cem:	09/1: b E	5/2010   F Tage	sahr sahr	Elmor Fun	ce. I	Maryland Home, P.A.	
ñ	Der Imp	10	<b>▶</b> €. ₩	$X' \propto$	ass	aln	1											and 21087	•
			23a. Part 1. Enter the shock, or heart fa	disease, or allure, List o	complicatio nly one caus	ns that cau se on each	sed the	e death.	. Do not en	ter the mo	de of dying	g, such as	cardiac o	or respiratory ar	rrest,			Approximate Interval Between	
~F	hysician/		Immediate Cause (Fina disease or condition	al		Atha	205	داد	ROHL	Ca.	Ldion	12564	lak	disea	250			Onset and Death	
	Medical Examiner		resulting in death)		<b>~</b> _	Due to (or	as a co	nseque	ence of):		-							,	
		er	Sequentially list condit if any, leading to imme	tions,	b. —	Due to (or	as a co	nseque	ence of):								- 4	_	-1
	ted 1 Insit	Examiner	cause. Enter Underlyir Cause (Disease or iinju	ng 🎏		24010(0)											- 4		
	executed an and rial-transi		that initiated events resulting in death) Las	t	с. —	Due to (or	as a co	nseque	ence of):										
	ite be hysicii he bui	dica		,	d												$\rightarrow$		_
09/89	certificate nding physuse as the	/Me	IF FEMALE:		23c If	yes, outco	me of n	reanan	CV					<del></del>					
	death ce he attend ed for us	cian	23b. Was decedent pre in the past 12 mor 1  Yes 2  N	nths?	1		th 2 🛚	Fetal	death 3	☐ Ectopic		У					te of deli nth	very Day Year	
G	the de by the ached	hysi	9 Unknown		9	☐ Unknov	vn												
O	s that igned by	by P	Part II. Other significa	nt conditio	ns contribut	ing to dea	th but n	ot resu	lting in the	underlying	cause giv	en in Part	I.					the cause of death?	
ďS,	equires sen sig ould to	ted											_	1 🗆	Yes :	2 🗌 No	3 🗌 Pr	obably 4 🗖 Unknown	٦
<u>o</u>	The law requires that the arte has been signed by the page 2 should be detach	Completed by Physician/Medical	***											24a. Was auto			Were aut orior to d death?	opsy findings available ompletion of cause of	
Ĭ	n: The ficate r, pag		25. Was case referred t	o modical							00.01	- (5		1 🗌 Yes				2 🔀 No	$\dashv$
/Ita	rsicial s certii lirecto	To Be	examiner?		Hospita	al:	nationt	2 □ E	R/Outpatie	nt 3 🗆 [	Otho	er:		me 5 Ed Resi	danaa	e <b>X</b> Oth	or (Space	daughter's	5
6	g Phy er this neral c		27. Manner of Death		-	a. Date of (Month,	injury	2	28b. Time o		28c. Injury work	at at		28d. Describe I				y.ome	
0	eath. or: Af the fu	ifica	2 Accident	Pendin Investig	ation					М	1 🗆	Yes 2 🗆	No						
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	4 Homicide	determi		e. Place of building			ne, farm, st	reet, facto	ry, office			28f. Location (S City or Tov			er or Rur	al Route Number,	
ב	spital		29a, Certifier 1	Certifying	Physician:	To the bes	t of my	knowle	dge, death	occured a	at the time,	date and	place, an	d due to the ca	ause(s) a	and mann	er as sta	ted.	$\dashv$
	ne Ho in 24 h ne Fui pleted	Medical												the time, date are, and due to the				ause(s) and manner state stated.	ed.
	Vith Vith To th		29b. Signature and title	of certifier	,	1 a A				29	c. License				29d. D	ate signed	d (Month	Day, Year)	
			) m	lail	Nh	100	ni	>			d i	355	22		Sa	femi	ner	13,20,0	_
	bV		30. Name and address	of person v		ed cause o	of death	(Item 2	23a) (Type,	Print)	AF	2	u As	YLAN	12	- 2	10 .	4 .	
	Stat	е	31. Date filed (Month, D	Day, Year)	J- 10	32. F g	strar's	Signatu	re	Land	1	- 0	F(//K	10/110	ن		101		
	Registra		\$	FP1	2010	Sen	wa	1	B. A										

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Steven Reyes		1- For State Registrar	tate of Maryla	-	ificate of		Jivientai		201 teg. No.	0 28893
Physic Medical Exam		1. Decedent's Name (First, Mide	-					2. Date of Dea Month	Day Year Pay Year er 12, 2010	3. Time of Death 0340 hrs
mealoui Exam		Steven Rey 4a. Facility Name (if not instituting)		mber)	4	b. City, Town, or	Location of De		4c. County of	
		University Hospital				Baltimore				
Funeral Director		5. Social Security Avended UNK	6. Sex	7. Age (In yrs. Iasi	t birthday) Yrs.	If Under 1 Year Months Days		/lin		Birthplace (State or Foreign Country)
any		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, To	own or Location	on				10d. Inside City Limits
and show a	5	MD Balt	imore	Balt	imore					1 X Yes 2 No
Maryla r 28a-f ed at o	Director	10e. Street and Number				10f. Zip Code			I0g. Citizen of Wha	t Country?
ith the 23a or notifi	al Di	1705 Wickes R		edent Ever in U.S.	13 \0/05	2123		Specify Yes or No	U.S.A.	Associate Indian Disab
leath w r items	Funeral	1 Never Married 2 N			If Ye	es, specify Cuban	, Mexican, Pue Pu	rto Rican, etc.)	White,	
after d	by F		vorced If Yes, Give Year or Dates:		1 X	Yes 2 No	specify: Ri	can	Specify:	White
2 hours "natu	ted	15. Decedent's Education (Specific Elementary/Secondary (0-12)				's Usual Occupat st of working life.			16b. Kind of Busi	iness/Industry
036 ithin 7 me. r than	Completed	12	,		Truck	Driver			Transp	ortation
15-0 filed w Hygie d othe	e Co	17. Father's Name (First, Middle	e, Last)	•					Maiden Surname)	<u> </u>
212 uld be Menta marke	O B	Edwin Reves 19a. Informant's Name/Relation	ship (Type, Print )		19b. Mailing	Address (Stree	Roni I		mber, City or Town,	State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Roni J. Medina	(mother)					, Bay Sho	ore, NY 1	
ore, eslan of Hea If iten		20a. Method of Disposition  1  Burial 2 Cremation	n 3 Removal fro		ace of Dispositematory or other	tion (Name of center place)		Date	20c. Location - C	City or Town, State
timent rtment ortant;		4 Donation 5 Other S 21. Signature of uneral Service		st.		Cemeter	-	/15/2010		mes, NY
Bal permi Depa Impo	L.O	21. Standard of uneral service	Licensee				-	551 N	. Counti	ry Road v 11780
Physician		23a. Part I. Ent the disease, of failure. List only one cause	r complications that car	used the death. D						
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		late int	oxicat	ion				Death
	Ш	Sequentially list conditions,	b	consequence or).						
	iner	if any, leading to immediate cause. Enter Underlying Cause		consequence of):						
sd sit	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):						
tox 68760, leath certificate be executed a attending physician and for use as the burial - transit	ledical I	X UNPENDED	d	5perFH,G	907,9/	29/10,WS	29/10			
760, icate be physic the bur	/Mec	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, or	utcome of pregnar	ncy				23d. Date of de	
x 68 h certifi ending use as	Physician/N	past 12 months?	I Live bil	th int at time of death		aldeath 3 [ er (Specify)	Ectopic preg	nancy	Month	Day Year
BO) he deatl	hysi		known 9 Unknov	A-52-5-55-1-5-6						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ā	Part II. Other significant condi	tions contributing to	death but not resu	ulting in the un	derlying cause g	ven in Part I.			ute to the cause of death?  Probably 4  Unknown
ord; aw requas been as been 2 shoul	Completed							24a. Was	osy prid	ere autopsy findings available or to completion of cause of ath?
tal Rec	5							1 ✓ Yes		Yes 2 No
/ital rsician: uis certi	o Be	25. Was case referred to medica examiner?  1 ✓ Yes 2 No	0 5 6	patient 2 🗸 EF	R/Outpatient		of Death (Chec		Residence 6	Other:
of \ing Phy ing Phy After th	-	27. Manner of Death	28a. Date o		8b. Time of Inj	ury 28c. Injur	y at Work?	28d. Describe	how injury occurred	
Sion Attendi death. ctor: 4	atio		ding estigation Fd 9/	12/10 F	d 3:15	an	es 2 No			ed on drug
Division of Vital Rec pital or Attending Physician: The Jours after death. heral Director: After this certificate filled in by the funeral director, page	ertification:	4 Homicide	lld not be 28e. Place (Specify)	of Injury - At home found:			uilding, etc.	28f. Location (S or Town, S Baltimo	Street and Number State) 1705 Williams Te, MD	or Rural Route Number, City LCKS AVE
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C		hysician: To the best aminer:On the basis of	examination and/						
5 1 × 1 8	Me	29b. Signature and title of certifi		itea.		29c. License	number		29d. Date signed	(Month, Day, Year)
J.		milli	, W.Z	L-		O.C.N	1.E.		September 1	3, 2010
TOKO		<ol> <li>Name and address of person Ling Li, MD Assista</li> </ol>	n who completed cause ant Medical Exam	•		, Baltimore, N	/ID 21201			
		31. Date filed (Month, Day Year)		strar's Signature						

10-070	18
Brenda	Rydzynsk
	Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		Reg. No.										2889		
Physician/ Medical Examiner		1. Decedent's Name Brenda K	, ,	, , , ,			2	2. Date of Death		Year	3	Time of Death 1056 hrs		
		4a. Facility Name (i 3310 Benso	f not institutio	ution, give street and number)			4b. City, Town, or Location of Death Baltimore					4c. County of Death Baltimore Cour		o Country
Funeral Director		5. Social Security N 215-40-6		6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days		Min.	8. Date of Bi	rth (MM/D	D/YYYY) S	9. Birthr oreign	place (State or
ny	ŀ	Usual Residence of		IVI ZZZ F		Yrs y, Town or Locati		<u> </u>	<u> </u>	12/24	/ 194			Od. Inside City Limits
rland f show a	ğ	MD		imore		Halethorpe								1 Yes 2 X No
the Mary	Director	10e. Street and Number 3310 Benson Avenue Apt. #408				10f. Zíp Code 21227				1	-	en of What nited		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	unera	11. Marital Status  1 Never Marrie	d 2 Ma	arried Armed Fo	12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of Hispanic Origin? ( St If Yes, specify Cuban, Mexican, Puerto			cify Yes or No ican, etc.)	14. Race - American Indian, Black, White, etc.			
ours after atural", c	d by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete			,	1 Yes 2 No specify:  16a. Decedent's Usual Occupation (Give kind of wo				Specify: White  ork done 16b. Kind of Business/Industry				
036 ithin 72 houng	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12				during most of working life. DO NOT use retired  Retail Sales				d)				dustry
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica								me (First, Middle, Maiden Surname) mma Christoforri						
MD 21 ad 2 should tht and Me n 27 is man	ا -	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number						er or Ru	Rural Route Number, City or Town, State, Zip Code) reet, Baltimore, MD 21230					
ore, Nges I and to GHealth	- 1	20a. Method of Disp	osition	3 Removal fro	20b. om State	Place of Disposi crematory or oth	tion (Name of cem er place)	netery,	l	Date	20c. Lo	ocation - Cit	ty or To	wn, State
Baltimore, permit. Pages I ar Department of Hee Important: If ites injury or other tr	7	Donation 5 21. Signature of Fun	Other Speed	ecify: _icensee	Ba	yview Cr	ematory ame and Address			4/2010 bbard 1	<u> </u>			Maryland
Physician	+	23a. Part I. Enter the failure. List only	disease, or o	complications that ca	used the deat	41 ( h. Do not enter th	07 Wilker e mode of dying, s	ns Ave	enue	. Balti	i more	⊃. Man	ryla T	Approximate Interval
/Medical Examiner		Immediate Cause (F or condition resulting	inal disease	Due to (or as a			ease	_			_		_	Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. First Industrying Cause.												
ted I Insit	באם !   באם !	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):												
e be executed sician and burial - transit		UNPENDED		d AMENDED										
Sox 6876 leath certificat e attending ph for use as the	ly Sicialities	F FEMALE: 3b. Was decedent p past 12 months?	anancy 2 Fetal death 3 Ectopic pregnancy ath 5 Other (Specify)				у	23d. Date of delivery Month Day Year			Year			
ires that the displayed by the detached by Dr. Dr.	236. Did tobacco use contribute to the ca													
Division of Vital Records, rial or Attending Physician: The law requirers after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed	non bien										sy		to com	sy findings available pletion of cause of
Vital I hysician: this certification of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country	3 2	<ol> <li>Was case referre examiner?</li> <li>1 ✓ Yes 2</li> </ol>		Hospital: 1 In	patient 2	ER/Outpatient		of Death (CI Other 4 \( \)			Residenc	e 6 🗸 O	ther: So	cene
ion of 'ttending Pheath. tor: After true funeral		7. Manner of Death 1 Natural 2 Accident	5 Pendir	ng	f Injury Day,Year)	28b. Time of Inj	. 1	at Work?	- 1	id. Describe h	ow injury	occurred		
Division of spital or Attending tours after death.  Increal Director: After filled in by the function: Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rural Route or Town, State)								Route Number, City					
To the Hos within 24 hu To the Fun completely	1/	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
		29b. Signature and title of certifier				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) September 13, 2010				
5 V		Ling Li, MD	Assistan	no completed cause	iner 111	Penn Street	Baltimore, M	ID 21201	1					
State Registra		1. Date filed (Month.	Day, Year)		etrar's Signatu	bar								
DHMH 17 Rev 1/2001						ORIGINAL				00	28.6			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

WICHAEI NOCK		1-For State Certificate Registrar		nygiene Reg. 1	2010	28895					
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last)  2. Date of Death									
1		4a. Facility Name (if not institution, give street and number) 3030 East Northern Parkway	4b. City, Town, or Location of Dear Baltimore		4c. County of Death						
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	y) If Under 1 Year If Under 24Hi		/M/DD/YYYY) 9. Birt	hplace (State or n Baltimore					
Director		219-94-2034   1   X M 2 F   45 Yrs.   Months   Days   Hours   Min.   April 5,1965   Foreign Balling Country   MD									
with the Maryland s 23a or 28a-f show any e.notified at once.	Ì	10a. State 10b. County 10c. City, Town or Lo		10d. Inside Ci							
	Director	10e. Street and Number 2532 Windsor Road	10g. (	10g. Citizen of What Country?							
			21234 Was Decedent of Hispanic Origin? ( §	Specify Yes or No-	U.S.A. o- 14. Race - American Indian, Black,						
er death	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puert  Yes 2 No specify:		White, etc. Specify: White						
iours aft natural" ixamine	od by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	f work done 16i								
036 ithin 72 l ne. r than "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Hea	erator	or Baltimore County							
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other traumatic event, the Medical Examiner must be notified at once.	8	17. Father's Name (First, Middle, Last) Thomas Franklin Rock, Sr.	ne (First, Middle, Maid Rae Swift	ft							
	٩			ral Route Number, City or Town, State, Zip Code) Parkville, MD 21234							
		1 Burial 2 Cremation 3 Removal from State Everance Character	position (Name of cemetery, Fether place) = 1 Se - Bel Air 2	pt. 12.1	oc.Location - City or Torest Hi						
Baltir permit. P Departme Importai		4 Donation 5 Other Specify: CHapel - Bel Air 2010  21. Signature of Funeral Service Licensee vans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234									
Physician /Medical		23a. Part I. Einter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death					
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Chronic Obstructive Pulmonaet Disease  Due to (or as a consequence of):									
	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
No. B. isi	Examiner	(Disease or injury that initiated events resulting in death) Last									
San and san san san san san san san san san san	Medical	X UNPENDED AMENDED 1,23a,pt.II,	27 g907 9-17-10 v	t							
68760 ertificate b ding physi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn		23d. Date of delivery Month Da	ay Year					
Box e death c the atten	Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Unknown	Other (Specify)								
P.O. es that the igned by	۾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Cardiomegaly, Narcotic Use  23e. Did tobacco use contribute to									
ords, aw requir as been s	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of					
l Rec n: The la tificate h or, page 2											
Vita hysician this cer	۱ <u>۵</u>	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati	ing Home 5 Resi	Residence 6 Other: Scene							
on of ending P ath. or: After the funer		27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time	of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how i	njury occurred						
Divisi tal or Att rs after de ral Direct led in by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	28f. Location (Stree or Town, State)	ocation (Street and Number or Rural Route Number, City Town, State)							
	Medical Co										
To with To cor	Me	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)							
2	}	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	36	eptember 7, 201						
9		Melissa Brassell, MD Assistant Medical Examiner 111	Penn Street, Baltimore, MD	21201							
Sta Registi	ate rar	31. Date filed (Month, Day, Year) SEP 15 2010 Server 32. Registrar's Gignatur Server	<i>P</i>			_					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 13, 2010 PHEMBER 13, 2010 **Physician** US+U5 10:35AM /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F Director 220-14-7289 19 85 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ems 23a or 28a-f sh r must be notified a X Yes 2 No Director Baltimore MD NA 10f. Zip-Code 10e. Street and Number 10g. Citizen of What Country? 3656 Hilmar Road 21244 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. items 2 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ŏ 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify. Black þ Specify: 3 Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Keswick Nursing Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 8th grade Nursing Aide Aide na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marvin Duffv Reecie Rew 7 is marke traumatic ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If item 27 is : or other tra Peggy Savoy-Daughter 4800 Cayle Road #310, Owings Mills, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department o Important; If any injury or once. Donation 5 Other (Specify) Garrison Forest Vet 9/20/2010 Owings Mills, Md of Aneral Service Licenses 2 Signati March F/H West 28a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Imme late Cause (Final **Physician** Due to (or as a 'onsequence of): weeks disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Year Month Dav Pregnant at time of death 5 Other (specify) ate has been signed by the at page 2 should be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Ves 2 No 1 Tyes 2 No 25. Was case referred to medical director. Be 26. Place of Death (Check only one) Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 1 Tyes မ 28a. Date of Injury this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 📈 Natural 1 Yes 2 🗆 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 Division of Vital Records, or Attending Physician: after death. filled in by the funeral the Hospital or Attending F hin 24 hours after death.

Baltimore, Maryland 21215-0036

completely

29a. Certifier

(check only

29b. Signature and title of certifier

SEP 1 5 2010

Medical

ANTHONY MD 31. Date filed (Month, Day, Year)

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature parke

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Smith 720 AM L. SEPT 2010 Arthur 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORI SINAI HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours 1 M 2 □ F GA 10 82 215-22-5075 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 1 Kes 2 No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 3807 Dorchester Road 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Long Shoreman Docks 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Effie Bishop Jerry Bishop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21215 3807 Dorchester Road, Baltimore, Justine Smith-Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 9/16/2010 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West tonald 23a. Parl 1. Enter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death mediate Cause (Final \* CARDIAC ARRHY 1 DAY disease or condition resulting in death) Due to (or as a consequence of): ATHEROSCUEROTI 10 YEARS DISEASE Se uential, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Petar vea. 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes - MASCULAR \_ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 □Yes 2 🖪 No 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Examiner requires that the death certificate be executed burial-tra physician s the burial attending p signed by Jas

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Pages 1

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Division of Vital Records.

Physician:

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Department of Heal Important: If Item 2 any injury or other once.

**Physician** 

/Medical

Examiner

Physician/Medical

Director

Funeral

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other traumatic event, the Medical Examiner must be positived at

timore, Maryland 21215-0036

page 2 certificate director this funeral 

within 24 hours after
To the Funeral Direcompletely filled in b

Completed by 25. Was case referred to medical Be examiner? 1∐Yes 2√ZNo Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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29c. License number

29d. Date signed (Month, Day, Year)

d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet

32. Registrar's Signal

Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harbor Hospital, Baltimore, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Betty R. Skipper SEPT 2010 12.05P M 12 /Medical Town, or Location of Death Baltimore 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) Examiner Augsburg Lutheran Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛣 F 213-26-7499 83 Director 1927 Maryland 11. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the fireficial Exp. in at must be rediffed at Baltimore Baltimore MD1 ☐ Yes 2X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country?
United States 21207 6811 Campfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ŽiNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bell Atlantic Special Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Heyn Effie Raye Wilhelm ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trains 1353 Holly Avenue, Dayton Chio 45410 Robert E. Skipper, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory of other place)

Even's Funeral (name) and Cremation Services Belair 9-14-2010 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licenses Evans Fineral Charlet and Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a surranguence of: Examiner burial-trans D.O. Box 68760公 Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: IF FEMALE: 23b. Was decedent pregnant the past 12 months? If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 mod 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by to Part II/Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 Yes 2 No 3 Probably Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1 ☐ Yes 2 4 25. Was case referre o medical examiner? director, 26. Place of \_\_ th (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ₩ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Mann of Death 28b. Time of Injury ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day ∠ Month Year Mor **Physician** 100 ar/tombor NOIU /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 🗆 F Days 369-36-5434 Director 8/10/1938 Michigan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at Maryland Baltimore Towson 1 Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21204 U.S.A. 1201 1/2 Malvern Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. i 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or iten 1 X Yes 2 If Yes, Give Year or Dates 1 ☐ Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Opthamologist Physcian 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Blum Phillip Silver ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, Maryland 21204 1201 1/2 Malvern Ave. Carole R. Silver / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of Important: If it any injury or conce. 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv. Corp. 9/13/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Euneral Service Licenses 1050 York Road Towson, Maryland 21204 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 011 Liverviolati IFFCISO disease or condition resulting in death) ) /Medical Due to (or as a consequence x: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Directo for an a pone coverage of and burial-tra resulting in death) Last Due to (or as a consequence of) death certificate be exec nding physician use as the burit Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 Z No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 🗌 No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 🗷 No 1 🗌 Yes 1 🗓 Inpatient 2 ER/Outpatient 3 🗆 DOA ည this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: of or Attending Part of the Court Natural
2 Accident 5 Pending investigation Injury 1 Yes 2 No completely filled in by the 3 🗌 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATIL KAUSTUBHA 600 North Wolfe St, Baltimore, MD, 21287 MO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		•	For State Registrar	State of M	arylario 7-19 <b>e</b> p Ce	ertificate of			Reg. No.	0 28901		
	Physicia		Decedent's Name (First, Middle, L     Mary	ast)	т	aylor		2. Date of De Month Septem		3. Time of Death		
· · · · ·	Medic Examin		4a. Facility Name (if not institution, g	ve street and number)			or Location of Dea	<del></del>	4c. County of			
and a second			Season's Hosp	ice		Ran	dallsto	wn	Bal	timore		
-	Funeral Director		5. Social Security Number 6.		e (In yrs. last birthday, 67 Yrs.	If Under 1 Year Months Days			th ay, Year) 5 43	9. Birthplace (State or Foreign Country) GA		
	d d	_	Usual Residence of Decedent  10a. State 10b. County	10d. Inside City Limits								
	arylan a-f sh fied a	Director	MD NA		10c. City, Town or L	imore				Yes 2 No		
	or 28		10e. Street and Number			10f. Zip Code		T	10g. Citizen of Wh			
	with t	Funeral	3458 Park Hei	ahts Ave		2	1215		U.S.	•		
	death items ier m		11. Marital Status	12. Was Decedent B	Ever in U.S. 13	Was Decedent of H		Specify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc.		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 X  If Yes, Give Year or Dates.	No	1 ☐ Yes 2 💆 No		. ,	Didort	Black		
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Maryland	be file antal H ked o c eve	일	17. Father's Name (First, Middle, Las	<sup>t)</sup> Unknown	Taylor				Maiden Surname)			
ary	and Missing Mark	. 1	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street		e Short ural Route Numbe	ar, City or Town, Stat	re, Zip Code)		
	id 2 sl ealth a n 27 is		Sidney Allen-	Daughter	345	8 Park	Heights	Ave, I	Baltimor	e, Md 21215		
Baltimore,	of He of Hiter or oth		20a. Method of Disposition	_	20b. Place of Disp		1	Date	20c. Location - C			
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Bal	Depart Depart Import any in		21. Signature of Funeral Service Lies	ack.	Ņ 4	arch Fd 300 Wab	H of West ash Ave	, Balt:	imore, M	id 21215		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Pnysician/	7	Immediate Cause (Final disease or condition	/	Kemia					Interval Between Onset and Death		
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on C	nding ath. r: Afte e fune	icat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day	, Year) injury	work			,,			
Division	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, si	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
۵	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifier 1 Certifying Pr	nysician: To the best of miner: On the basis of o	my knowledge, death	occured at the time	e, date and place,	and due to the ca	use(s) and manner a	as stated. the cause(s) and manner stated.		
	the H thin 24 the F mplet		only one) 3 L Certifying No	urse Practioner: To the	best of my knowledge	death occurred at th	ne time, date and p	ace, and due to the	e cause(s) and mann	er as stated.		
	5 W W		29b. Signature and title of contifier	Mr. 1.	,	29c. Licens	e number 4 05-3		29d. Date signed (A	Month, Day, Year)		
	5		30. Name and address of person who	completed cause of di	eath (Item 23a) (Time					, - , - ,		
	0			charm m	0 6934	AVIA H	be Blu	1 21	061			
	Stat Registra	.ᠸ	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Ne.	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28902 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20ได้ September 9:20 A Shirley M. Treu Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Morningside House Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 🗆 M 2 🕱 F Hours 11-29-1923 New York Director 083-18-1204 86 Usual Residence of Decedent 28a-f show 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State Director 1 🗌 Yes 2 🙀 No Maryland Howard Ellicott City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Suite 206 5330 Dorsev Hall Drive 21042 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. <u>S</u> 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: "natural", 3 

M Widowed 4 □ Divorced White Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked o Violet VanGehuchten ပ Harold M. McDermott 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne T. Davis (Daughter) 10323 Wilde Lake Terrace Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any injury or o ŏ Atlantic Crematory 9-11-2010 Glen Burnie, Maryland 22. Name and Address of Facility
Witzke Funeral Homes,
5555 Thin Val 21. Signature of Funeral Service Licensee Inc 555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that cause shock, or beart failure. List only one cause on each line Immediate Cause (Final the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ dementia cerebrovascular disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 3 years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami anding physician and use as the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ p in the past 12 months?
1 Yes 2 No Pregnant at time of death Yes 9 Unknown 9 Unknown s been signed by t should be detach Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Squamous cell 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has l page 1 ☐ Yes 2 ☐ No Yes 24 N 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 No Hospital ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 5 Pending 24 hours after death. Funeral Director: Aff bleted filled in by the fur 2 🗌 No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

Registrar
DHMH 17 Rev 7/2009

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State

Lonso

8955

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H.D

32. Re

Alonso

D.

31. Date filed (Month, Day, Year)

032482

Guilford Rd, Suite 140, Columbia MD 21046

September 10, 2018

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #201 Per FH G907 9/15/10 Jh amend #201 State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Sept. 2010 3:25 P M Mathilde Scheurer Tolbert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clem and Doll Assisted Living Baltimore Randallstown 8. Date of Birth
(Month, Day, Year)
Nov • 14,1919 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday, **Funeral** 1 □ M **XIX**F Hours 90 **Director** 217-34-8982 Germany Usual Residence of Decedent show or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director Ba1timore Reisterstown 1 ☐ Yes XX No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ural", or items 23a or Examiner must be Funeral 411 Central Ave. 21136 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes XX No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White If Yes, Giv "natural" XX Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Health Care 8 Nursing Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Philipp Scheurer Elisabeth Hambsch 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Marie Tolbert Central Ave. Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9/21/10 Garrison Forest XX Burial 2 Cremation 3 Removal from State 9/14/10 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) ans Cemetery 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Dement-a disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a some equation of) Exami attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the a Id be detached fo 2 40 g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsv death? Hospital or Attending Physician: The 1 ☐ Yes 2 ☑ No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED LIVE Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 ☐ Yes 2 ☐ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 051153 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 Winker State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,11,12,15,16a&b, 18&19a&b Per ANA BD C907 9/15/10 JH State of Maryland / Department of Health and Mental Hygiene 28904 1 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1205 PM intemper 3 William Taylor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore er 1 Year | If Under 24 Hrs If IJnde 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Davs Hours Min. (Month, Day, Year) ar 9, 1927 Country)
Virginia Director 214-22-8965 83 Mar Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4669 Falls Road 21209 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1951 1 Hes 2 No 1953 If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 XXivorced black Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk (Specify only highest grade completed) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha College (1-4 or 5+) <del>vn</del>k Laborer Railroad Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 1122 Nettie Jones 19a. Informant's Name/Relationship Type, Print)
Lamont Taylor son
Union Memorial Hospi 19b5 Gring Address Street and Number or Bural Bouta Number. City or Jawn, State Zin-Code)
201 F. Walter Bouta Number of Bural Bouta Number. City or Jawn, State Zin-Code) Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state Signature of Typeral Service Livensee Wade State Attatomy aboard 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Emer the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or I art failure. List only one cause on each line.

Immediate Caus. (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 L 9 Unknown 9 Unknown sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 
Yes 2 completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 KER/Outpatient 3 IDOA After this 27. Manner of Death
1 A Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 5 Pending Investigation within 24 hours after deat To the Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifie 29c. License number tenber 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ September 10, 2010 Etta Tiernev 12:40 aM Μ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore . Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 - M 2 X F Months Days Hours Sept 27 87 **Director** Maryland 214-18-5158 Usual Residence of Decedent show 10a. State with the Maryland "natural", or items 23a or 28a-f sho 10c. City. Town or Location Director Md. Baltimore 1 Yes 2 X No Towson 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 106 Kenilworth Park Dr. #2A 21204 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black White etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. White Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant. If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Worker Phone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Parker Marie Sautter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Barbara Farren/ Niece 44 Roger Valley Ct. Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Important: If any injury or Oak Lawn Cemetery 4 Donation 5 Other (Specify) 9-14-10 Baltimore, Md. <sup>22. Name and Address of Tows</sup>on Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of unera Servio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph/sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Day to (or as a consequence of cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director Attending Physician: the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death Unknown ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

þ Completed Be 25. Was case referred to medical 잍

examiner?
1 \( \sum \) Yes 2 \( \sum \) No

27 Manner of Death

Natural

Accident
Suicide

4 Homicide

29a. Certifier

(Check

24a. Was an autopsy Yes 2 No

1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

2 🗌 No

Pertant

1 Yes

26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

To the Funeral Director: After this certificate I completed filled in by the funeral director, page

Certificate:

Medical

. CR 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 15 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER R 12, 201012:25P M Frances R. Tierney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GREATER BALTIMORE MEDICAL CENTE BALTIMORE TOWSON 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Confierticut 045-22-8258 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Baltimore Maryland Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Completed by Funeral 500 Fairway Court 21286 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💢 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene is marked other tha Secretary Lega 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Generoso Renzulli Rosa Cemmenillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10014 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau Barbara Tierney / Daughter 29 Charles Street Apt 4B New York, New York 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date HIlltop Serv. Corp 1 Durial 2 X Cremation 3 Removal from State 9/17/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ schemic disease or condition one day Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death ed by the a Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \triangle \) Nursing Home 5 \( \triangle \) Residence 6 \( \triangle \) Other (Specify) 1 Yes 2 1 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0043 Man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles Touson 21204

State Registrar 31. Date filed (Month, Day, Year)

6535

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ gertanber 2810 3:15 PM Patricia White - Jerry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges Co. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Davs Hours Min 12-3-1951 Washington, DC Director 58 578-72-7856 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits MD P.G. College Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code or items 23a or 10g. Citizen of What Country? Funeral 6214 Westchester Park Drive, #A 20740 U.S.A. should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: Black 3 - Widowed 4 - Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 9th College (1-4 or 5+) event, the Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Pinkney Sr. Adline Thompson 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald O. Jerry, Sr. -Husband 6214 Westchester Park Dr., #A College Park, Md. 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State cemetery, crematory or other place)
MD. Veterans Cemetery 09-23-2010 cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home . Signature of Funeral Service Licenses 108 W. North Avenue, Baltimore, Maryland 21201 23a Part 1. Enter the disease, or campications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ardie disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 ☐ Yes 2 🎦 No 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar sick Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Altie Mingu N. P. 81/8 Good Luc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 28908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Rose Marie Wilzen 2114 AUGUST 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9000 SAMARITAN HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
11/29/1916 9. Birthplace (State or Foreign Social Security Number Funeral Days Hours 1 M 2 XF 93 Director 400-44-1153 Germany Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No MD Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 5411 Walther Blvd. 21214 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ื No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Coat Factory Seamstress UNK UNK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Aging 10 N. Calvert Street, Baltimore, MD 21202 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. 8/27/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 2829 Hudson Street, Skarda F.H. Baltimore, Md 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner URINARY IRACT INFECTION Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a nonsequence of Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transii resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Day g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BREAST CANCER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DEMENTIA 24a. Was an autopsy OSTEDARTHRITIS 2 🗌 No Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Naturai iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

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WI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

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29d. Date signed (Month, Day, Year)

OCH RAVEN BLUD BALTIMORE MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WILLIAM 4:15 M -JOHN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ANNE ARUNDEL CERTIZ MAPOLIS MEDICAL MD XEUNDE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min (Month Day, Social Security Number Funeral 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign N/A 1 X M 2 - F Director Country) laryland Usual Residence of Decedent show 10b. County 10a. State death with the Maryland at Director 10c. City. Town or Location 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a MD Anne Arundel 1X Yes 2 No Annapolis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 201 Hanover Street 21401 U.S.A. items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No 10 Black, White, etc. Completed by 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. Specify: White "natural", 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Dependent Not Self Supporting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Justin Loyd Woods Tera Lynne Utley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justin Loyd Woods (father) 201 Hanover Street, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 9/17/2010 Fredericksburg, TX Greenwood Cemetery 21. Signature of Fureral Service Licensee T. Harman Schaetter Funeral Home 22. Name and Address of Facility 78624 SUN 301 E. San Antonio Street, Fredericksburg, TX 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dulmosa Medical Examiner phragn Sequentially list conditions, if any, leading to minimadiate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🗶 No 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death Day Year the g 🗌 Unknown g Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) မ Other: 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛭 Natural 5 Pending work death. 1 🗌 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check within 2 To the I only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar Duzanne

31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month ELEANORA WILLIAMS 7.45 AM Sept. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Pre Health of Rehale. 51LVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Mar 13, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Yrs. Virginia 577-78-1679 83 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it we Medical Examinar must ke notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2601 Bel Pre Road 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: black 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Agee Cornelius Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau 20032 4221 4th Street SE #7 Washington, DC Walter Williams/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 \ Other (Specify) in state icensee Wad 21. Sign ture of Funeral Service 22. Name and Address of Facility etor State Anatomy Board 655 W. Baltimore Street Mre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca e (Final disease or condition resulting in death) **Physician** GASTRIC CANCER Monies /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 1 ☐Yes 2 No 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Cerebro varcular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ovenin certificate has autopsy 2100 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 53411 81 2010

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State Registrar 14300

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatur

Gallant Fox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS, G907, 9/15/2010 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month G. Physician/ 5:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PL m If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day, 1 M 2 P Months Days Hours Min. 217-26-4614 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No Ta 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 344 13. Was Decedent of Hispanie Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cubar Black, White, etc. 9 þ 1 Never Married 2 Married 2 No Yes 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Completed 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) conday (0-12) Elementary/Se College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) m. May 21239 MD injury or other 20b. Place of Disposition (Name of cametery, crematory of other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3-3010 al timore, 21. Signature of Funeral ervice Licensee Services 22. Name and Address of Facility avann Greene Funeral any in 21133 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Colorectul disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death g 🔲 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy After this certificate has Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** Be 26. Place of Death (Check only one) Daughter's Hospital: Other: Other (Specific Residence Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Μ 2 🗆 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 MD Broady BACTIMORE LUIS DIAZ 32. Regist. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Wilkens Hattie Physician/ 2:30 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Home Nursing If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Ry Carolina 21822 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 Imore 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) conday (0-12) College (1-4 or 5+) Restaurant th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ unK. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ohnsor 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD21229 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shook or heart failu Immediate Cause (Final disease or condition resulting in death) or heart failure. List only one cause on each line Interval Between Onset and Death ~Ph\_sician/ wnan Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading technical tecause. Enter Underlying Examiner Due to lor as a conse wence of Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes Natural 5 Pending 2 🗌 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

Registrar

940

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDHU

32. Registrar's Signature

REETINDER

SEP 1 5 2010

31. Date filed (Month, Day, Year)

BALTIMORE ST.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Jeannette Whitmer-Nelson <u>September</u> 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Fairhaven Nursing Home Sykesville Carroll If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔯 Months Davs Hours Min. Dec 15, Year 1909 Indiana 100 Director 011-12-9776 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2x No Sykesville Carrol1 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21784 USA 7200 3rd Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Specify: "natural", Completed 3 ¥ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) curator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cline Keys Dora Carmack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Whitmer/son 7200 3rd Avenue Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature Funeral Se State Anatomy Board 655 W. Baltimore Street Baltimore. MD Approximate Interval Between Conset and Death 23a. Part \ Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or con Ution resulting in death Physician/ provasce Medical Que to (or as a consequence of): **Examiner** Sequentially list conditions, in any, loading to immediate cause. Enter Underlying Examine Due 13 (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other 2 100 မူ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completed filled Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tile

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

5 2010

1645

32. Registrar's Signature

ldress of person who completed cause of death (Item 23a) (Type, Print)

QM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Weber Month ougus) Charles 1:00 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 102 Old Farm Court Glen Burnie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Jan 12, 1946 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 🕅 M 2 🗆 F Mary land Director 212-42-6093 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Tyes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Old Farm Court 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2X Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. white 3 Widowed 4 Divorced Year or Dates. 164-69 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Navy 12 aircraft carrier 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h Ruth Rose Linthicum Matthew Charles Weber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 01d Farm Court Glen Burnie, MD 21060 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Rotanna Weber/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) cemetery, crematory or other place) . Signature of Europeal Service Licenses North 25 tame and Address of the Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lancer Physician/ una disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 Yes 2 g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a Was an page 2 s autopsy performed certificate 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica **Division of Vital** 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manper of Death 28b. Time of 28c. Injury at work? Certificate: Natural 5 Pending 1 🗆 Yes 2 🗆 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

NSIMMAMM D.

29c. License number

D0057465

29d. Date signed (Month, Day, Year)

9 18/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S.-RUMPALSE MD 2835

Smith N-5-235

Baltimore, MD. 21207

**State** 

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 09, 2010 Shirley May Wilson 9:50 A.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death

Baltimore County 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Center Towson . Social Security Number Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2**X** F Months Davs Hours Min (Month, Day, Year)
Dec. 05, 1931 226-42-9228 Director 78 Alexandria, VA Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d Inside City Limits Director ms 23a or 28a-f sł must be notified a 1 Yes 2X No Cockeysville Baltimore County Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 United States 1502 Worthington Heights Pkwy. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White Yes, Give 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Music Education 12 02 Piano Teacher Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Mary Catherine Harrison Mead Hammond Kendrick, Sr. 19a. Informant's Name/Relationship (Type, Print) (Husband) 21030 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Health tem 27 i 1502 Worthington Heights Pkwy Cockeysville, MD. Mr. John Scott Wilson,Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place).

Evens Funeral Chapel and Cremation Services, Inc. 20a. Method of Disposition 20c. Location - City or Town, State (Harford Co.) Date permit. Page 1
Department of
Important: If it
any injury or o ō 1 Burial 2 Cremation 3 Removal from State Sept. 10,2010 4 ☐ Donation 5 ☐ Other (Specify) ForestHill,Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 1914 Lic. 100677 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. Timonium, Maryland 21093-2215 2325 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ all disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Vear 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 □ Nursing Home 5 □ Residence 6 Nother (Specify) Hospital Other: 1 Yes 2 XNo ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at e Hospital or Attending P n 24 hours after death. e Funeral Director: After t 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Natural 5 Pending Accident Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. N2 0 1 0 28916

Physicia /Medic **Examin** 

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinating to an other an outled at appear.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, WALTERS, THOMAS H.

	1 - State Registrar	Olato of Mic	C		te of Dea			leg. No.	010	28916	
	1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea Month	th Day	Year	3. Time of Death	
ian ical	Thomas Herbert W	alters, Sr					SEPT	Day	8 20		
ner	4a. Facility Name (If not institution, giv	e street and number)		4b. City,	Town, or Loca	ation of Death		4c. (	County of Dea	ath	
		SPITAL			ILTIMO						
	5. Social Security Number 6. S	Gex 7. Age	e (In yrs. last birthde	Months		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day		0	rthplace (State or Foreign Country)	
	213-30-3397		77 Yrs.				June 2.	5, 19	933 M	aryland	
	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. Inside City										
ρ											
rec	MD         Baltimore         Woodlawn           10e. Street and Number         10f. Zip Code         10g. Citizen of What Co										
0	6011 Charles Str	eet			21207						
Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 1			nic Origin? (Spe	ecify Yes or No- Rican, etc.)	USA 1	4. Race - Am Black, Wh	nerican Indian,	
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d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1953-55	10103	ZEGITO OP						
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E G	Elementary/Secondary (0-12)	College (1-4or 5	)+)					m	1		
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Be							Margare				
은	19a. Informant's Name/Relationship (		19h M:	ailing Addres			al Route Numbe			. Zip Code)	
	Lavern Walters	Wife		_			oodlawn			,,	
	20a, Method of Disposition		20b. Place of Dis				Date	-		or Town, State	
	1 Burial 2 Cremation 3		Loudon			v 9/14/	2010	alti	more,	MD -	
	4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Lices		2-2-20	22. Name a	and Address of	Facility Ste	rling A	shtoi	n Schwa	ab Witzke	
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	23a. Part 1. Enter the disease, or com	iplications that caused	the death. Do not	enter the mo	de of dying, su	ich as cardiac	or respiratory a	rest,	11119	Approximate Interval Between	
Į.	shock, or heart failure. List only one cause on each line.										
•	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  b. Horring Communication with Gangrene  b. Horring Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Com										
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Completed by Physician/Medical	IF FEMALE:										
an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		3 ☐ Ectopic	pregnancy			2	23d. Date of o	delivery Day Year	
Sici	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 Other (s	specify)					<b></b> ,	
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2	rait ii. Other significant conditions	contributing to death b	at not resulting in the	e underlying	cause given in	i diti.		Yes 2[		Probably 4 Unknown	
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gu							24a. Was autoj		prior t death	autopsy findings available to completion of cause of	
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Yes 2   No									)		
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Medical	(Check only 2 Medical Exa	miner: On the basis of and manner st	of examination and/o	or investigation	on, in my opinio	on, death occur	rred at the time,	date and	f place, and c	due to the cause(s)	
Me	29b. Signature and title of certifie			25	9c. License nu	mber		29d. Da	te signed (Mo	onth, Day, Year)	
	1617	(SWFF	REDA MD		P 250	907		S	ept 9	, 2010	
	30. Name and address of person who	completed cause of	death (Item 23a) (Ty	pe, Print)							
		PITAL 9	1005. CA	TON A	VE B	ALTIN	IORE,	MD	21	229	
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trar	SEP 1 5 2010	Carrie	P. Ma								

Registrar

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Division of Vital Records, P.O. Box 687607

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician Doris Louise Wall** September 10 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Altimore CITY HOSPITAL of BAltimore N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 □ F Director Feb 12, 1916 No. Carolina 223-34-1881 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the "Addeal Eventine"; ust by nothing at 1 X Yes 2 No Director Kernersville No. Carolina Forsyth 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 27284 308 Brookside Court death v Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2☐No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 9 **Black** 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Mae Lassiter Mack Lassiter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. 308 Brookside Court Kernersville, N.C. 27284 Lucille Green 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 09/13/10 Baltimore, Maryland Arbutus Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART ATherosclerotic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ypertension ₽ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed iteari ongestive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 100 2 No certificate 1 TYes 1 ☐ Yes funeral director. Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 Inpatient Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? Injury 5 ☐ Pending investigation n 24 hours after death.
he Funeral Director: Af 1 ☐Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cestif September 10, 2010 D0054558 30. Nam and address of pers who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL of BAltimore BURKE, JR MO EDERICK 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 12,18 per fh g907 9-20-10 vt. State of Maryland / Department of Health and Mental Hygiene

Amend Item 18 per fh,g907,09/24/2010dhb

Certificate of Death

Reg. No. 20 | 0 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1:05 PM John Kostas Zaharis 0 20/0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin

5. Social Security Number Roseda If Under 1 Year Baltimore Square Hospital .le\_ If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Hours Min. Days 1**√** M 2 □ F 83 214-20-6241 10 1927 Director September Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Exy virus must be notified at 1 ☐ Yes 2√ No Director County Baltimore Baltimore Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 21236 4555 Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1\(\(\)\(\) Yes 2 \(\) No If Yes, Give Year or Dates: 1945–48 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, Ita Nagonee. Elementary/Secondary (0-12) College (1-4or 5+) Route Salesman Vending Company 10 18. Mother's Name (First, Middle, Maiden Surname)
Sophia Feggara
Spohia Zeggara Feg 17. Father's Name (First, Middle, Last) Be Feggara Kostas John Zaharis ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21236 Nottingham, Marvland Nancy C. Zaharis 4555 Ridae Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery September 15 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home Cother 2833W 7401 Balair Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner tonitis 25 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physiclan the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was an autopsy performed?
Yes 217 No Hospital or Attending Physician: The certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ၉ 9/10/2010 85000c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammed Alhaji 9000 Franklin Square Drive Baltimore, MD 21237 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

John

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month 11:12 A M Barbara Anne Abell September 9. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death St. Mary s Avenue 23289 Colton's Point Road 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Months Days Hours Min Country) Maryland Director 219-34-9894 73 Yrs. February 9 1937 Usual Residence of Decedent fshow 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f sl notified 1 🗌 Yes 2 🔀 No St. Mary's Maryland Avenue 10e. Street and Number 10f. Zip Code r items 23a or iner must be n 10g. Citizen of What Country? filed within 72 hours after death with Funeral 23289 Colton's Point Road 20609 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or ite the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner age 1 and 2 should be filed with of Health and Mental Hygie t: If item 27 is marked other for other traumatic event, the Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Garrett Russell Elsie Jane Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alison A. Beavan 24965 Beavan Court, Chaptico, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Aloysius Cemetery Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 🖾 Burial 2 🗌 Cremation 3 🗍 Removal from State September 13, 4 ☐ Donation 5 ☐ Other (Specify) 2010 Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 21. Signature of Funeral Service Line 1996 23a. Part +. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons au nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 X No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) I Director: After this d in by the funeral di Manner of De tl 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nursa Practioner: To the best of my knowledge, death occurs within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -10 30. Name and addr of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SEP 1 0 2010

Linear B. Januar

D.O.

Jennifer Merry Schmidt,

40900 Merchants Lane, Suite 205, Leonardtown, MD 20650

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ames William i	Butle	1- For State	tate of Maryla		artment of		l Mental Hy	_	201	0 28920
Physici	an/	1. Decedent's Name (First, Mid-	dle,Last)					2. Date of Dea	ath	3. Time of Death
Medical Exam	iner	odines william						Month August 3	Day Year 1, 2010	0911 hrs
		4a. Facility Name (if not instituti 141 Elkmore Road	on, give street and nu	ımber)		4b. City, Town, or L Elkton	ocation of Death		4c. County of Cecil	Death
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	If Under 24Hrs.	9 Date of Bi		Birthplace (State or
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Ore,	1	1 Burial 2 Crematio	n 3 Removal fro		crematory or oth		etery, 9/2	Date 2/2010	20c. Location - Ci	ity or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other S 21. Signature Tuneral Service		R. 7		l Funeral		.A.	Rising	Sun, MD
Ba perm Depa Impo injur		21. Signal and unleral service	7/1 21		l R.	ame and Address of T. Foard	and Gee		wp 01001	
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/Medi J Examiner	/Medi fairre. List only one cause on each line.  Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease							Between Onset and Death		
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Division of Vital Records, rat or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	ifica		d not be	of Injury - At ho	ome, farm, street	, factory, office buil	ding, etc. 2			r Rural Route Number, City
Divis Hospital or Ai 24 hours after d Funeral Direc tely filled in by	Certification:	4 Homicide	mined (Specify)				1	or Town, St		
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To the within To the compl	Medical	29b. Signature and title of certifie	and manner st	ated.		29c. License n			29d. Date signed	
		D-m ).	- n			O.C.M.			September 1,	
	-	30. Name and address of person	who completed cause	e of death (Item	23a)					
10+14A		Donna M. Vincenti, Mi	O Assistant M	edical Exam	niner 111	Penn Street, B	Baltimore, MD	21201		
Sta Regist	-13-4	31. Date filed (Month, Day, Year)		gistrar's Signatu						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Reg, 8907, 282 f pe me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, 8907, 1237 to another the me, For State Registrar 2892 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Charles Aloysius Brooks 1405 Medical August 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b, City, Town, or Location of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number Funeral . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 **№** M 2 🗆 F Days Hours Min. (Month, Day, Year) 05/13/1934 Director 218-30-4362 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21335 Brighton Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 K Married 1 X Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools School Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Brooks Mildred Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Brooks/Spouse 21335 Brighton Ave., Lexington Park, MD 20653 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans 09/01/2010 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Signature Juneral Printe Scender
Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final espirator Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): ematoma hit for Dr. Titus Examiner Fai Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown 9 I Inknown P.O. | ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records, is certificate has been si director, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to hedical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: မြ n 24 hours after deatn. **ne Funeral Director:** After this or spleted filled in by the funeral director. 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury Division work? 1 ☐ Yes 2 X No. 08/20/2010 **Unknown**M Subject fell. Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 21335 Brighton Ave. Lexington Park, MD 4 Homicide determined Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D62213 25 10

Registrar

State

Haration

22650 Cedar Lane Ct., Leonardtown, MD 20650

ate

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 30

Registrar
DHMH 17 Rev 7/2009

State

3001 Hospital Drive, Cheverly, MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re

istrar's Signature

Manash K. Das

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 50 OTH 2010 2:40 PM AMES EDWARD 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Vear | If Under 24 Hrs. Huenue OMICO 5. Social Security Number If Unde 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Director 214-05-1809 5/01/1918 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show must be notified at 1 Yes 2 No Director OMIC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status "natural", or item: edical Examiner n Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1943 – 44 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black þ 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) クナか Naval Department of Health and Mental Hygie Important: If item 27 is marked other I any Injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Booth ပ Bertha Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta E. Savoy(Daughter) 1003 Marquis Ave Salisbury, Md. 21801 Baltimore, 20b Recs of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Memorial Park 8-27-10 Annapolis, Md. 21. Signature of Funeral Service Licenses Manuame Research of Lacil Cons Mortuary, P.A. Larry 4, Bless MOOY 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician OROW ARY ARTENRY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed KIDNEY HRNK and burial-trar CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE asn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Jas autopsy certificate 1□ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1X Yes 2 ER/Outpatient 3 DOA မ 1 ☐ Inpatient this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. d tide of certifie 29c. License number 29b. Signature ar 29d. Date signed, (Month, Day, Year) 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) 31413 WINTOTUPLACE AL SUITE 43 SMISBURY MD ZISCY PO GTILEMAN 31. Date filed (Mont State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Director

Funeral

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Completed

Be

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Examine

Completed by Physician/Medical

Certificate: To Be

Medical

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attending physician for use as the buria

Physician/

Medical

**Examiner** 

**Funeral** 

Director

	Plea	se Type or State o							<b>All Copie</b> Mental Hy			jible.		
For State Registrar						ate of L				Reg. N	00	10	28924	
1. Decedent's Name (First,		,								2. Date of Death 3. Time of De				
CATHERINE									AUGUST	25,	<sup>2</sup> 201	<b>O</b> Year	12:25 P <sup>M</sup>	
a. Facility Name (if not ins			· ·	пев	4b. (	City, Town, o		of Death		4		of Death		
MANDRIN CHES  Social Security Number	s. last birthda		HARW nder 1 Year	If Under	24 Hrs.	8. Date of Bi			9. Birth	NDEL place (State or Foreign				
220-40-6290		1 □ M 2 <b>X</b> F		<b>69</b> Yrs	. Mon	ths Days	Hours	Min.	JUNE th, P	4, Year	941	MAR	YLAND	
Jsual Residence of Deced 0a. State 10b. 0	ent County		10c.	City, Town or	Location								10d, Inside City Limits	
MARYLAND A	NNE	ARUNDEL		,,		APOLI	S						1 Yes 2 X No	
0e. Street and Number						. Zip Code				10g. C	itizen of	What Cou	ntry?	
1103 SMITH	VILL	E STREET	, T10			214	01			U	NITE	D ST	ATES	
1. Marital Status		12. Was Dec	edent Ever in	U.S. 1	3. Was De	ecedent of H	ispanic Ori n, Mexicar	gin? (Spe	ecify Yes or No- Rican, etc.)	-		e - Americ	can Indian,	
1 Never Married 2 3 Widowed 4 N Di		If Yes, Giv				s 2 <b>X</b> No					Specify	DT	ACK	
		Year or D 's Education	ates.	16a. De	cedent's l	Jsual Occup	ation			16h	Kind of B	usiness In	aduetry.	
(Specify onl		t grade completed College (1		) (Gi	ve kind of	work done ( use retired)		t of work	ing	100.	KING OF B	usilless III	idustry	
12		J. Jones				SEAMST	RESS			D	RY C	LEAN	ING	
7. Father's Name (First, M.  VINCENT CY)	-	,	WN						e (First, Middle NE JEAN			*		
9a. Informant's Name/Re	lationshi	p (Type, Print)		19b. Ma	ailing Add	ress (Street	and Numbe	er or Rura	al Route Numbe	er, City c	or Town, S	State, Zip (	Code)	
RAMONA LONG	/SIS	TER		861	2 FLI	JTTERI	NG LE	AF I	RAIL, U	JNIT	202	, ODE	NTON, MD 2111	
Da. Method of Disposition 1 🏻 Burial 2 🕱 Crer		3 Removal from	20b	o. Place of Dis cemetery c	sposition ( rematory	Name of or other plac	e)A	MGUS	Date 26.	20c. l	Location -	City or To	own, State	
1. Signature of Euneral Se	er Ce Lic	censee	) EKO		CREMA ROAD	and Address TION ANNA	s of Facilit AND F POLIS	UNEI UNEI S, M	LOWS AR ARYLAND	ELFI 214	ENBE	IN &	E, MARYLAND NEWNAM BESTGATE	
shock, or heart failure shock, or heart failure mmediate Cause (Final disease or condition resulting in death)	e. List on	_ a C	or as a cons	C	anc		g, such as	cardiac	or respiratory ai	rrest,			Approximate Interval Between Onset and Death	
Sequentially list conditions any, leading to immediat ause. Enter Underlying Cause (Disease or linjury	s, te	b. — Due to	(or as a cons	equence of):								+		
hat initiated events esulting in death) Last		c. Due to	(or as a cons	equence of):										
FEMALE: 3b. Was decedent pregna in the past 12 months' 1  Yes 2 No 9 Unknow			Birth 2 🗆 F nant at time o	etal death 3		oic pregnanc r (specify)	у				23d. Da	te of deliventh	ery Day Year	
art II. Other significant o	ondition	s contributing to a	leath but not	resulting in th	e underlyi	ng cause giv	en in Part	l.	23e. Did t		No	3 🗆 Pro	he cause of death?	
									24a. Was auto perfo 1  Yes		1	orior to co death?	psy findings available impletion of cause of	
i. Was case referred to me examiner?	edical	Hospital:	-			Othe	ace of Deat	th <i>(Ch</i> ec	k only one)	•	<b>N</b> (1)	100	211, 11	
	Pending Investiga	28a. Date (Mon	Inpatient 2 of injury th, Day, Year)	28b. Time	of	28c. Injury work	4 ⊔ Nu at		ome 5 Resi 28d. Describe I		1	er <i>(Specily</i> ed	The House	
3 Suicide 6	Could no determin	ot be 28e, Place	of Injury - At ng, etc. (Spec	home, farm, s	street, fac	tory, office			28f. Location (3 City or Tov			er or Rural	Route Number,	
(Check 2 ☐ Med	dical Exa	Physician: To the baminer: On the bas lurse Practioner:	ils of examinat	tion and/or inv	estigation	, in my opinio	n, death oc	curred at	the time, date a	and place	e, and due	to the car	use(s) and manner state	

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and cate has been signed by the atterpage 2 should be detached for the completed filled in by the funeral director,

State Registrar flance weens, us

29c. License number DS2830 29d. Date signed (Month, Day, Year)

August 25, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeanine Welner, MD, 900 Best gut Road, Amepolis, ND 2401

31. Date filed (Month, Day, Year) AUG 2 6 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 28925 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Maurice Burkey 2120 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death **Examiner** medicalCenter HILLGANL Cumberland MHS-Kegional 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months OCE 28, 1 ★ M 2 □ F 217-28-0684 78 Marvland 1931 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at **Funeral Director** 1 Tyes 2 K No Cumberland Allegany 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 U.S.A. 11719 Iowa Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Labor - Tire Builder Manufacturing Rubber 12 other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Leora Thelma (Beal) Charles Edward Burkey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 Apache Court, Galena, IL 61036 19a. Informant's Name/Relationship (Type, Print) 325 Apache Court, Galena, IL Marlene Jahncke Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Sept 8, 2010 Sunset Mem Park Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Hafer Funeral Service, 22. Name and Address of Facility 1302 National Hwy., LaVale, MD h. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease, shock, or heart failure. Lis or complications that caused the Immediate Cause (Final Onset and Death Physician/ Ence disease or condition Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 🗌 Yes 25 1 Department 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 \( \subseteq \text{Yes} \) 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury 1. Natural 5 Pending 2 🗌 No Investigation Accident 6 🗆 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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o death (Item 23a) (Type, Print)

address of person who completed causi

32,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month RANDOLPH BUSSARD FRANCIS 2010 9:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Month, Pay,
July 1 X M 2 □ F Days 213-24-9371 87 Maryland **Director** Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Frederick Frederick 1 Yes 2X No Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** USA 21702 7104 Rock Creek Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Dairy Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Viola Frushour Edna Lawson Bussard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7104 Rock Creek Drive, Frederick, Maryland 21702 Viola G. Bussard/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Crossnickle Brethren Sept.10,2010 Myersville, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 504 Main Street 21. Signature of Fund 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 7. Inter thy 10.35, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown r heart failure. List only one cause on each line. nterval Between Immediate Cause (Final disease or condition Onset and Death Encephalogath Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Uniontrolled UTN Completed 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Box 68760 P.0. Records, Division of Vital

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

Lakhvinder Date filed (Month, Day, Year,

SEP 1 5 2010

estell MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wadhwa

32. Registrar's Signatu

400W 74h St

back

D0063498

Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 2010 PAULINE THERESA BERMEL ept. 5:02 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days country) Rand Months Hours Min (Month\_Day 213-26-5974 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD. Baltimore Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 21093 Dulaney Valley United States death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) (Disabled) None ulth and Mental Hygie 27 is marked other r traumatic event, th Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be iment of Health and Menta John Bermel Pauline Theresa Eber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Thomas Bermel (Brother North Furnace Rd. Jarrettsville MD. 20a. Method of Disposition
1 ☐ Burial 2 Å Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 8 Sen cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Cremation amnstead Maryland Signa 22. Name and Address of Facility E.G. Kurtz & Son Funeral any. Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, n e. ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition eurs Medical resulting in death) o (or as a consequence of): Examiner Sequentially list conditions, if they leading to immediate cause. Enter Underlying Examiner Due to for as a pursecuence offi the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical SEPTEMBER 5, 20 18, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2.2 No death? Hospital or Attending Physician: The certificate 1 🗌 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1XNatural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 No М death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier LECTIFYING Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif License numbe 29d. Date s SOLD mestine

Registrar

State

31. Date filed (Month, Day, Year)
32. Registrar's Signature

ERNESTINE WRIGHT,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

Division of Vital Records.

P.O. Box 68760.

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 25 2010

30. Name and address of

DHMH 17 Rev 1/2001

Charles Brett Hofmann, M.D. - 30434 Mt. Vernon Road - Princess Anne, MD 21853

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D 0059931

29d. Date signed (Month. Day. Year)

August 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amended item#1, WCHD, SLU, 09.02. Certificate of Death 1. Decedent's Name (First, Middle, Last) Clemens Henry Brittingham 2. Date of Death Physician/ 3:40 PM Clemens Randolph Brittingham, Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbur the 0 mic Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 M 2 🗆 F Country) MD Months Hours 72 220-32-7894 Director 1938 Aug Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director Worcester Ocean City 1 XYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8803 Coastal Highway 21842 USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🙀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married African-Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Laborer Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Hazel Purnell Clemens R. Brittingham, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Purnell/daughter 2203 Groton Road, Pocomoke City, MD 21851 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 MBurial 2 Cremation 3 Removal from State St. Paul UMC Cemetery 9/4/2010 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, 1618 West Rd., Salisbury, MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MYRLOWA MULTIPLA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS/ICL 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mapner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

SEP 0 1

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Registrar's Signatu

1973 SAGBUY mp 21801

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		artment of H		lental Hygie	2010	28930
i	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Y	3. Time of Death
	/Medic	al	Lessie  4a. Facility Name (If not institution, giv	Baskerville		4h City Town or	Location of Death	August 2	4c. County of	9:30 P M
	Examin	er	11908 Pitt Drive				shington			nce George's
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. I	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9	Birthplace (State or Foreign Country)
L.	Director		227-56-0891	1□ M 2 <b>X</b> F 69	Yrs.	I Days	Tiodio Iviai.	Dec 18,		Virgínia
G Z I Z I 3-0030	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Mary -f sho	tor	Maryland Prince	George's	Ft.	Washingto	m			1 ☐ Yes 2 ☐ No
	h the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of Wha	at Country?
	23e c	aiD	11908 Pitt Drive			207	44		United	States
	er dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Y	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
0000	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
3	2 hou		15. Decedent's E	ducation	16a. Deced	dent's Usual Occupa	ation	16	b. Kind of Busir	
2	thin 7;	ple	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work f)	ing		
7	ed wit	Completed		4	Opera	ating Roo				ical
ב ב	tal Hydrath deven	Be	17. Father's Name (First, Middle, Last					e (First, Middle, Ma		
2	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene ittem 27 is marked other than "natural", or Items 23e or 28a-f show that traumatic event, the Medical Examinar must be notified at	2	MIlton Saxto		10h Mailie	a Addrass (Ctroot	Mildre	ed Alber		lliott
2	d 2 sl th and 17 is r traur	l	Cecil Baskervill		1				Charles and a	
ก	tem 27 tem 27 tem 27		20a. Method of Disposition	20b. P	lace of Disno	8 Pitt Dr				yland 20744 ty or Town, State
2	Pages nent of I ant: if its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	_Removal from State		matory or other plac	- 1	27/2010 1	Moodhine	e, Maryland
Dallillor	_ t # # #		21. Signa e of Funeral Service Lice		22	. Name and Addres	ss of Facility			-
Ď	Departing any irr		Quanto R	Homes MO095	57   G	oing Home everly L.	Heckroti	on Service Le, P.A. (	e P.O. I	Box 784 ille, MD 21029
			23a. Part1. Inter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.						Approximate Interval Between
-1	Priysician		Immediate Cause (Final disease or condition	, Atherosclerot	tic Car	rdiovascu	lar Disea	ase		Onset and Death unknown
	/Medical Examiner		resulting in death)	Due to (or as a consequ						
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<u>.</u>	execuna and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					UIRIOWII
000	cate be executed physician and the burial-transit	dicai		d. Hyvertensic		unknown				
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מכא	ath ce ttendi or use	hysician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Fetal	Ideath 3	Ectopic pregnancy			23d. Date of Month	
	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5∟	Other (specify)				,
Ŀ	that the death certific ed by the attending p detached for use as	۵.	Part II. Other significant conditions of	contributing to death but not resi	ulting in the u	nderlying cause givi	en in Part I.	23e. Did toba	cco use contrib	ute to the cause of death?
cords,	uires sign ld be	d b	Renal Failure					1 🗋 Yes	2 □ No 3	☐ Probably 4 ☑Unknown
5	w requires that s been signed b should be deta	iete	Sacral Ulcer					24a. Was an	24b. We	re autopsy findings available
ב	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as	Completed by						autopsy performs 1 ☐ Yes 2 5	d? dea	or to completion of cause of ath? ] Yes 2 ☐ No
		Be C	25. Was case referred to medical				26. Place of Deal	h (Check only one)	Q NO	7.00 2010
5	<b>Physician</b> : The lav this certificate has ral director, page 2	To	examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3 DOA Othe	er: 4 🗌 Nursing Ho	ome 5 <b>X</b> Residenc		
5	ing P	on:	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	k?	28d. Describe how	injury occurred	
2	ttand death stor: / the f	icat	2 Accident investigatio		ome form etr		Yes 2 □ No	28f Location (Street	et and Number	or Rural Route Number,
2	after Direction by	ertification:	4 ☐ Homicide determined	28e. Place of Injury - At ho ilding, etc. (Specify	/)	eet, factory, office		City or Town,		or marer route reambor,
_	To the Hospital or Attanding Ph within 24 hours atter death. To the Funeral Director: After thi completely filled in by the funeral	O	29a. Certifier 1 X Certifier 9 Pl	nysician: To he best of my know	Wiedge, deat	occurred at the thi	ie, date and place,	and due to the cau	sc(s) and mann	er as stated.
	ne Ho n 24 ł ne Fu oletely	edical	(Check only 2 Medical Example)	miner: On e basis of examinal a manner stated.	tion and/or in	vestigation, in my o	pinion, death occur	red at the time, date	and place, and	d due to the cause(s)
	To the Vithing Comp.	ž	29b. Signature and title of certifier	Maralle		29c. License		290		Month, Day, Year)
		n	pun	JUWELLE	ans	D 5	0454		August	24, 2010
		15	30. Name and address ol person who	//						
	-0		Arastoo Yazdani 31. Date liled (Month, Day Year)	M.D. 9135 Pisc 32. gegistrar's Signa	cataway	Road, Si	uite 235	Clinton,	Maryla	and 20735
	Sta Registr		AUG 272	010 32 Hegistrar's Signal	B. 4	arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 10-06378 Dorothy Amelia Boyd 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1708 hrs August 23, 2010 Medical Examine Dorothy Amelia Boyd 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7, Age (In yrs. last birthday) **Funeral** Social Security Number 220-05-5050 Months Days Hours Director \_M 2XF Country) 7/28/1919 MD 214-12-8349 91 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 10a State 10b. Count 1 Yes 2 No or 28a-f show , or items 23a or 28a-f shor must be notified at once. Columbia Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be marified at now. MD Howard rector 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 5400 Vantage Point Rd., Unit 315 21044 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes 1 Yes 2 No specify: Specify: White 4 Divorced If Yes, Give Year 3 Widowed ş or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Cesky Allen Quinan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3269 Danmark Dr. Glenwood, MD 21738 Charles M. Bovd - Son 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition Important: If, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 8/28/10 Marriottsville, MD Mt. View Cemetery Donation 5 Other Specify 22 Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licensee M01044 Old Columbia Pike Ellicott City. MD 21043 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line (Medica) Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and sician/Medical AMENDED UNPENDED s been signed by the attending physician should be detached for use as the burial -P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ğ 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available certificate has been autopsy performed? prior to completion of cause of death? ✓ Yes 2 No page 1 Yes 2 No 26. Place of Death (Check only one) Hospital or Attending Physician: ector, 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Subject passenger of vehicle involved in motor Aug 23, 2010 Natural 1617 hrs 1 Yes 2 ✔ No 5 Pending vehicle accident 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Rt. 424 & Farrell Street, Crofton, Md. determined (Specify) Major Road / Highway 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Assistant Medical Examiner Theodore M. King, Jr., MD. 31. Date filed (Month A 16 C 2 32. Rajistrar's Signature Bresch

M. 30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

and manner stated.

**ORIGINAL** 

29c, License number

O.C.M.E.

**OCME** 

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 24, 2010

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William John Cornwell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional A mical 8. Date of Birth (Mo)th, Day, Year) 08/15/195 Birthplace (State or Foreign Country) **Funeral** Months Days 1 🛛 M 2 🗆 F Hours 59 228-68-9021 Director Virginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Snow Hill 1 X Yes 2 No Maryland Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21863 USA 266 S. Washington St Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: white If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) electronics IBM assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rena Edith Crouch Cumberland Cornwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 266 S. Washington St., Snow Hill, MD 21863 Candy Cornwell/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Anatomy Gifts Registry 9/1/2010 Hanover, MD . Signature of Furieral Sc <sup>2</sup> Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between rt 1. Enter the disease, or complications that cau hock, or heart failure. List only one cause on each I Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as conse uence of Examiner Sequentially list conditions. Examine ue to (or as a consequence of if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or impury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the at Id be detached fo Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 100 Hospital 2 XV0 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 Natural Accident 5 Pending work? 1 \sum Yes 2 \sum No Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of pertition 29c. License number 29d. Date signed (Month, Day, Year) 6464 me and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar's Signature

CAROLING Carr 224-18-3614

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	_		For State Registrar			,	tificate of L			Reg. No. 2	010	28933
	Physicia		Decedent's Name (First, Middle, Lass     Caroline Carr	t)					2. Date of De Month August	Day	Year 2010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give		- /-		4b. City, Town, o			4c. Cou	unty of Death.	
	Funeral		Peninsula Regional  5. Social Security Number 6. Se	2x 7. Age	Centure (In yrs. last bi		If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th	#100M10	place (State or Foreign
	Director		224-18-2614 <sup>1</sup> Usual Residence of Decedent	□ M 2 <b>x</b> F	92	Yrs.	Months Days	Hours	Min. (Month, Da Aug 27	, 1918	Coun	VA
	yland f show ed at	1 1	10a. State 10b. County	70	10c. City, Tov						1	0d. Inside City Limits
	or 28a- or or 28a-		MD Wicomi		Salli	SDUL	Y 10f. Zip Code			10g. Citizen	of What Cour	
	th with the ms 23a must b	Funeral	416 Rose Street	Armed Forces? If 1 ☐ Yes 2 ☐ Yoo If Yes, Give 19ear or Dates.			21801  Was Decedent of Hispanic Origin? (Specify Yes or No f Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:				USA	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced								14. Race - American Indian, Black, White, etc, African— Specify: American	
215-(	an "nat Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)			(Give I	dent's Usual Occup kind of work done O NOT use retired)	during most of	working	16b. Kind o	of Business In	dustry
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lanc	should be filed of and Mental Hyg is marked other traumatic event.	70 E	James B. Garriso	n					e Mears	waiden Sum	ame)	
Mary	2 shoulk th and N 7 is ma trauma		19a. Informant's Name/Relationship (Type, Print)  Lorenzie Carr/son  19b. Mailing Address (Street and Number or Rural Rout)  16 33 Waconia Dr., Salisbu									
re, l	1 and 2 of Healt fitem 2		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place		Date		on - City or To	own, State
timo	tt. Page rtment rtant; II njury or		1	v)		Acr	es Mem P	ark 9,	/3/2010	Salis	bury,	MD
Ba	permir Depar Impor any ir		21. Signature of Funeral Service Licens	too			Name and Addre EWIS N. 618 Wost	Watson	Funeral H	Iome, P	PA 201	
	III SASSESSA		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line		not ente	er the mode of dyir	ng, such as car	rdiac or respiratory a	rest,	,,,,	Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	a. Due to ( r as a	consequence	e of):						
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	executed an and rial-transit	Examiner	cause, Enter Underlying Cause (Disease or iinjury that initiated events  c.									
_	be exec sician ar burial-t	resulting in death) Last  Due to (or as a consequence of):										
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P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)						23d. Date of delivery  Month Day Y		
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Division of Vital Records,	he law req te has bee age 2 shou	Completed							24a. Was auto perfo			psy findings available mpletion of cause of
talF	ician: T sertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:			lou	er.	(Check only one)			
of V	g Physical this or	te: To	1 Yes 2 No  27. Manner of Death	1 Inpatie 28a. Date of inju		Outpatier  Time of injury	π 3 LI DUA	y at UNursi	ing Home 5 Resi 28d. Describe			)
sion	ttendin death. stor: Aft / the fur	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b					Yes 2 N		Street and Nu	imher or Rura	Route Number,
Divis	tal or A rs after al Direc ed in by		4 Homicide determined	building, etc		Tall 77, 311			City or To		THOU OF HEILE	Tidato Nama di,
	e Hospi 24 hou e Funer leted fill	Medical	(Check 2 Medical Exam	sician: To the best of ner: On the basis of e se Practioner: To the	xamination and	d/or inves	tigation, in my opini	on, death occu	rred at the time, date	and place, and	d due to the ca	use(s) and manner stated.
_	To the within To the comp	2	29b. Signature and title of certifier	2 m.1 -			29c, Licens	e number			gned (Month,	Day, Year)
	3		30. Name and address of person who	completed cause of de	eath (Item 23a	) (Type, F		222			08-2	7-10
	Sel		RAZA AFZAL MD  31. Date filed (Month. Day Vand	100 E. CA	RROLL	St	SALISH	ury 1	md 218	201		
	Sta Registr			32 Aegistra	ar s Signat	A CO	akai					

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 6, Physician/ 2010 8:55 a.mM Matthews Dean Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Days Months Hours Min. (Month, Day, Year 1 / 0 1 / 1 9 2 86 Maryland Director 216-22-2744 Usual Residence of Decedent 28a-f show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must <u>be notified at</u> 10a. State 10h County 10c. City, Town or Location Director 1 Yes 2 X No Maryland | St. Mary's Leonardtown 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 20650 21714 Meadow Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other 1 any injury or other traumatic auch 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances Large Wilmer T. Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43935 Sandy Bottom Road, Hollywood, MD William R. Dean/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Aloysius Cemetery 09/10/2010 Leonardtown, Maryland ard N. Brinsfi 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Road, Leonardtown, MD Hollywood ward N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 Yes 2 No Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed Yes 2 death? or Attending Physician: The 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: ျ 1 Tes 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After work? 1 Yes 2 No 1 Natural 2 Accident 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 114285

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Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who co

31. Date filed (Month, Day, Year,

William D. Boyd II, M.D.

25365 Point Lookout Road, Leonardtown, MD

impleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 2010 5:20 AMM LIZETTE THOMAS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ST. MARY'S HOSPITAL MARY'S LEONARDTOWN . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Min. OCT 25 1 Hours MARYLAND 81 (928 Director 216-28**-**0945 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No MARYLAND HOLLYWOOD ST. MARY'S 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? "natural", or items 23a o Funeral USA 20636 25115 NOLAN ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates WHITE 3 X Widowed 4 Divorced Completed th and Mental Hygiene.

77 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MARGUERITE MAAS JOHN BOSLEY THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 WATER STREET, SW NBU 5-4, WASHINGTON, DC 20024 27 EUGENE DEVERE DAY (SON) If item 2 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 

Burial 2 

Cremation 3 

Removal from State 09-04-2010 CHARLOTTE HALL, MARYLANI BRINSFIELD-ECHOLS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 22955 HOLLYWOOD ROAD BRINSFIELD, M00052] BRINSFIELD FUNERAL HOME, P.A. LEONARDTOWN, JR. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Squamous Cell Concer. Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Secureotially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Vear Month Day Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? σ. by certificate has been sign irector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical of Vital 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🔲 No 1 Natural injury 5 Pending Division To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29c. License number 29d, Date signed (Month, Day, Year, D060473 2010 10 pms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20650

DHMH 17 Rev 7/2009

State Registrar Mehrdad

31. Date filed (Month,

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Mary

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day September 2 2010 Vernon Stern Dilks 1040 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ceci1 Laurelwood Care Center E1kton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) March 27, 1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 1∭ M 2□ F Maryland 215-14-8143 83 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 X Yes 2 No E1kton Marvland Ceci1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 100 Laurel Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? World 1 Xi Yes 2 No If Yes, Give War II Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify 3 X Widowed 4 ☐ Divorced Year or Dates: White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander M. Dilks Ethel M. Knight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 North Tartan Drive, Elkton, MD Terry L. Cullum/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) September 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Elkton Cemetery 8, 2010 Elkton, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD Approximate Interval Between Onset and Death Dementia years. Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e, Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

certificate be executed

Box 68760,

P.O.

Division or Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show notified at

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items 23a

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filed within Hygiene.

permit. Pages 1 and 2 should be filed I Department of Heath and Mental Hygic Important: If Item 27 is marked other I any injury or other traumatic event, III

Director

Funeral

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within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

Examiner Physician/Medical þ

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Certification:

Medical

29b. Signature and title of certification in the signature of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and title of certification in the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the sig

S. S. Sachder MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

physician s the burial as signed by the a has funeral director, this ( death. I or Attendi efter death. Director: A

To the Hospital o within 24 hours eft To the Funeral

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

9.8.2010.

Registrar DHMH 17 Rev 1/2001 0023322

126 A, E High ST, Elhton MD 2/921.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT DAVIS 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death REGIONAL WOOMIC TENINSULA Social Security Numb If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours (Month, Day, Ye. 09/16/49 Director 226-64-2019 60 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Deg artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🕱 No VΑ ACCOMACK MAPPSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29277 DAVIS DR 23407 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No If Yes, Give Specify: Completed 3 - Widowed 4 Divorced Year or Dates. 1969 BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ENTREPRENEUR TRUCKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ROBERT DAVIS. HELEN COPES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA WATSON - FRIEND PO BOX 9 MAPPSVILLE VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation FAMILY CEM. 08/28/10 ATLANTIC. VA ion ture of June 19 Cooper & Humbles Funeral Co. Accomac mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ily one cause on each line. Approximate shock, or heart failure. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury rale Des that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signal 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.
Funeral Director: After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signeture and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 26

Please Type or Print in Black Indelible Ink, Fryure All Copies Are Legible.

Amend Item 21 per FH G90 Ink, Fryure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ 0:18 P M 2 Dukes 2010 Alison Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico ce 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Country)
Maryland (Month, Day, Yea -19-1939 Months 1 🛛 M 2 🗆 F Director 214-42-9467 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2🏋 No MD Wicomico Eden 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21822 USA 3748 Stockvard Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married 2 Married John DuKes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Agricultural Farmer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dukes June Montgomery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3748 Stockyard Road, Eden, Maryland 21822 June Dukes Owens - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Wicomico Memorial Pk. 4 Donation 5 Other (Specify) 9-4-2010 Salisbury, Maryland Bounds Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Melissa Blake per DVR 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ MYRLODYSPLASTIC Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events.) Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death 4 Pregnant : 9 Unknown been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 1No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy perform 2 THO 1 Yes 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) of Vital funeral director, Be examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) Residence Other (Specify) 2 1 No HOSPICA 2 1  $\square$  Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After 5 Pending injury work? Natural Division Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 12058410 Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO Stay our 733 6 Huyan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Agnes Dennis 30,2010 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Salisbury Rehabilitation & Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Wicomico Salisburu If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Min Months Davs Hours 1 □ M 2 🛛 F 219-14-3545 9-25-1924 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No MD Wicomico Pittsville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 6579 Friendship Road USA 21850 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Watson Minnie Birdell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 512, Selbyville, Delaware 19975 Janet Murray - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Friendship Cemetery 9-4-2010 Pittsville, Maryland 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only obe cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 10 mars 6221 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for as a consequence of Cons ear-Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 100 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other

or Attending Physician: The law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, attending physiclan the as esn ţ the þ signed I page 2 should has certificate this After

**Physician** 

/Medical

Examiner

**Funeral Director** 

2

Completed

Be ( ၉

**Funeral** 

Director

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant; If item 27 Is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Profical Examination must be notified at

permit. Page: Department o Important; If any injury or

**Physician** 

/Medical

Examiner

Maryland 21215-0036

Baltimore,

Physician/Medical þ Completed Be Certification: To

Medical

Examiner

completely filled in by the funeral 24 hours after death Funeral Director: Hospital within 2.

I res 2	140	' 1  Inpatient 2	ER/Outpatient 3	3 🗆 🗅	DOA 4 Lat Nursing H	rsing Home 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1 Matural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)						
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fy)	facto	ory, office							
29a. Certifier (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
29b. Signature and	title of certifier	111		2	9c. License number	-	29d. Date signed (Month, Day, Year)					

lic Ave Salisbury, MD 21804

State Registrar

SEP 0 1

William H. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-06700 Joseph Michael Downs Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 28941

Certificate of Death

		Registrar		Certific	cate of	Deam			Reg. No.		
Physicia	an/	Decedent's Name (First, Mid-						Date of De     Month	Day Year	3. Time of Death 1248 hrs	
/ledical Exami	ner	Joseph M  4a. Facility Name (if not institut		wns	- 14	b. City, Town, or	Location of D		per 5, 2010		_
		33969 Maryland Line			٦	Massey	Location of Di	caur	Kent	n Bodin	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9									_
Director		151-62-8216	<b>₩</b> 2 F	45	Yrs.	Months Day	s Hours	Min. 9-22	-1964	Foreign Country) NJ	
		Usual Residence of Decedent									
/ any		10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limit	
Maryland 28a-f show any <u>d at once,</u>	ъ	DE	Kent		Camd	en-Wyoı	ming			1 Yes 2 X N	0
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with the Maryland ns 23a or 28a-f sho be notified at once,						1993			USZ		_
th wit	Funeral	11. Marital Status  1 Never Married 2	12. Was Decedent Married Armed Forces	>		Decedent of His s, specify Cubar		(Specify Yes or Nerto Rican, etc.)	lo- 14. Race White	- American Indian, Black, e, etc.	
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5-0036 led within 72 hours al Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12	College (1-4 or	5+)	_	ast of working life $-\mathtt{emplor}$		retired)	Heating	g/air cond.	
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	۲	Tonya Downs								oming, DE	-
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and N Important: If item 27 is in nigury or other traumatic.		20a. Method of Disposition				tion (Name of cer	metery,	Date	20c. Location -	City or Town, State	_
nor ages ant of art. If			on 3 Removal from St		itory or oth	rem.Se	rv. 9	-7-2010	Wyomi	ing, DE	
	1	4 Donation 5 Other S 21 Signature of Funeral Service			22. N	ame and Address				Home, Inc.	
Balt permit. Depart Impor injury	19	-	1991	z, 			_		Wyoming,		
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/Medical <i>≣</i> xaminer		Immediate Cause (Final diseas			mia					Death	
1		or condition resulting in death)	Due to (or as a cons		thae	toxicity	V				
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons				/				_
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<b>∞</b> ∄ ≅ [	ian/	23b. Was decedent pregnant in past 12 months?	December 1	Alana at ala atta		al death 3	Ectopic pre	gnancy	Month	Day Year	
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Division of Vital Records, P.O. Box 6 the Hospital or Attending Physician: The law requires that the death cer hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attendin phetely filled in by the funeral director, page 2 should be detached for use.		Part II. Other significant cond	litions contributing to deat	h but not resulti	ng in the ur	nderlying cause o	given in Part I.	23e. Did	tobacco use contril	bute to the cause of death?	_
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Division tal or Attendii rs after death.	Certification:	det	uid not be	ehicle	farm, stree	t, factory, office b	building, etc.	28f. Location	State) 33969 Aassey M	er or Rural Route Number Cit Maryland Lin ID	ě
Division of To the Hospital or Attending Phywrlin 24 hours after death. To the Funeral Director: After I completely filled in by the funeral		4 Homicide	Physician: To the best of m		eath occurr	ad at the time da	ate and place				_
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To To cor.	Me	29b. Signature and title of certif	fier and manner stated.			29c. Licens	e number		29d. Date signe	ed (Month, Day, Year)	_
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_		3 Name and address of person	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	leath (Item 23a)							_
5.		Theodore M. King, J		ledical Exan	niner	111 Penn St	reet, Baltim	nore, MD 2120	)1 		
St Regis	tate trar	31. Date filed (Month, Day, Year	7) 32. Registra	s Signature	1 1	ald					
		SEP I	D ZUIU KEN	u p	17				<del></del>		_
DHMH 17 Rev 1/2	100			O	RIGÍNAL	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death :08 Physician/ M 2010 Robert Bernard Esau Medical Facility Name (if not institution, give street and Examiner Town, or Location of Death County of Deat Glan Burnie If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Aug. 29 Age (In yrs. last birthday, If Under 1 Year 9. Birthplace (State or Foreign Funeral 1 ★M 2 □ F Months Country)
Maryland 71 215-40-5072 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 604 Westmoreland Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examisone. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Utility Company Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Irene Hoffmann Henry Esau 19a. Informant's Name/Relationship (Type, Print) ab. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Westmoreland Place Severna Park, MD 21146 Mary E. Esau / Wife Baltimore, 20b. Place of Disposition (Name of August 2010 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematroy, INC. Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 21146 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Year Month Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed within 24 hours after death.

To the Funeral Director, After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) 2 X No Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 5 Pending work? 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 2010

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person

31. Date filed (Month

who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

IRIA

2 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 28, 2010 Physician/ 1:08 A M Mary Ann Foote Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Hospital 8. Date of Birth (Month, Day, Year)

Dec. 16, 1941

9. Birthplace (St Country)

Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director 213-42-5750 68 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD St. Mary's Mechanicsville 10f. Zip Code 10e Street and Numbe 10g, Citizen of What Country? Funeral United States 20659 40335 Parlett-Morgan Road 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary C. Burch Paul Leonard Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Foote / Husband 40335 Parlett-Morgan Road, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Aug. 29, 2010 Alexandria, Virginia Metropolitan Crematory 21. Sign dure of a ner I Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 0 David A. Goff or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 23a. Part 1. Enter the dise Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ M.Notes rdine disease or condition ) Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \triangle \text{ Nursing Home } 5 \) Residence 6 \( \triangle \text{ Other (Specify)} \) 2 No 1 Tes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA ၉ After this 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 A Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 🗌 No Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. MD 20650 Matthew Grzegozen

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland /		rtment of H		nd Me	ental Hyg	giene	010		11000
			Registrar			Cer	tificate of D	eath			Reg. No	<u>. U I U</u>		28944
	Physicia Medic		1. Decedent's Name (First, Middle, L ARLENE	FL	116	h	um			2. Date of Dea Month HUG	ath Day 22	2°1		3. Time of Death 32 48 M
-	Examin	er	4a. Facility Name (if not institution, gi		ew H	230	4b. City, Town, or	Location of I	Death	115	4c. C	County of Dea	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	
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	od 10w	<u>-</u>	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	ation						100	Inside City Limits
	arylar a-fst	ecto	MD Anne A	rundel	Too. Oity, 10		apolis							1 ☐ Yes 🛠 No
	or 28 e noti	Dįr	10e. Street and Number	L dirde 1	i	711111	10f. Zip Code				10g. Citize	en of What Co		
	with s 23a ust b	Funeral Director	210 S. Southwoo	od Ave.				2140	1		_	USA	,	
	death items	Fun	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. W	/as Decedent of His Yes, specify Cubar	spanic Origin	n? (Speci	fy Yes or No-		4. Race - Ame		ndian,
36	after (I", or	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 🗌 Yes 2 🗆 If Yes, Give	No		Yes 2xXNo		001011	ouri, oto.,	S	Black, Whit pecify:		nite
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215	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho et the Medical Examiner must be notified at	Completed by	(Specify only highest selementary/Seconday (0-12)	grade completed)  College (1-4 or l		(Give k	ive kind of work done during most of working e. DO NOT use retired)					101 Busiliess	illuusi	ı y
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کّ	should be and Me is mark aumatic		19a. Informant's Name/Relationship		10	9h Mailin	Address (Street a					State 7	in Code	-1
ž	and 2 sh Health a tem 27 is		Stephen J. Schef	Broth fer Law	er n l		Fifth Av				-			
Baltimore,	L of Fig.		20a. Method of Disposition 1		20b. Place cemen	of Dispos	ition (Name of atory or other place	- :	Da			ation - City or	-	
ţ	permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (Spe	cify)	Knes	eth ]	srael		8/25	/2010	Anna	polis,	MI	)
Ba	permit. Departn Importa any inju		21. Signature of Jun, al Service Lice	e		12	Name and Address Ridgely	<sup>s of Facility</sup> I • Ave •	Hard An	esty Funapolis	unera	1 Home 21401	, F	.A.
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause y each line	the death. Do		the mode of dying	, such as ca	ardiac or r	espiratory arre	est,		Ар	proximate erval Between
Ť	hysician/		Immediate Cause (Final disease or condition resulting in death)	a Art	erios	e/e	rotie	1-te1	Art	Di	501	75-R		set and Death
	Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):								
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Box	death ne atte ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnancy Other (specify)	, 				Month	Day	/ Year
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ds, P	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	ed by					asilying cases give							y 4 X Unknown
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æ	rsician. The law is certificate has k lirector, page 2 s		05.11							perfor 1 Yes		death?	s 2 [	No
<u> </u>	sician certif irector	m	25. Was case referred to medical examiner?  1   Yes 2 □ No	Hospital:	· · · · · · · · · · · · · · · · · · ·		0.11	ce of Death (						
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ono	ending sath. or: Aft. he fun	licat	1 Natural 5 Pending 2 Accident Investigation		(, Year)	injury	M 1 □ Y	′es 2 □ No	0					
Division of Vital	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			farm, stree	et, factory, office		28	f. Location (St City or Town		lumber or Ru	ral Rou	ite Number,
_	lospita I hours uneral ed filled	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of e	my knowledge	, death oc	cured at the time,	date and pla	ace, and o	due to the cau	se(s) and r	manner as sta	ated.	
	the H thin 24 the F mplete	We	only one) 3 L Certifying Nu	rse Practioner: To the	best of my know	wledge, de	ath occurred at the	time, date an	nd place,	an <b>d d</b> ue to the	cause(s) a	nd manner as	stated	·
	5.≱ <b>5</b> 8		29b. Signature and title of certifier	1	De,	put	7 29c. License		2-1	1 2	9d. Date s	signed (Month	n, Day,	Year)
~	1, -	ļ	30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, Pri					<i>N</i>	1 2.	)	/ /
(	43		Milliam P	JONE	r's Signature	10	69	5	1	ner	CA	21	10	35
	Stat Registra	e r	31. Date filed (Month, Day, Year) AUG 26	2010 32. Higher		. A	all							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 28945 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Earl E. Fountain Aug 2010 1435 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 12 Elzie Lane Crisfield Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 17 M 2 □ F 69 160-32-7067 Director Apr 21, 1941 PA Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evanine must be notified at MD Director Somerset Crisfield 1 Yes 2 □ No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 12 Elzie Lane 21817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? XYes 2 No Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural", or i Baltimore, Maryland 21215-0036 African-1 ☐ Yes 2 🛣 No Specify: <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o any Injury or other trans George Fountain ဂ Gertrude Kersey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eliza Fountain/wife 12 Elzie Lane, Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 9/7/2010 22. Name and Address of Facility
Lewis N. Watson Funeral Home, PA 21. Signature of Funeral Service License. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCUL ORVI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician; The law requires that the death certificate be execute Due to (or as a consequence of): burial-1 Box 68760 physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No. 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy certificate performe Division of Vital 1 □Yes 2 🗆 No 24 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Uother lainty at 28d. Describe how injury occurred 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) Manner of Deal 28b. Time of After 28c. Injury at Work? Hospital or Attending Natural 2 Accident 5 Pending a Hospina. In 24 hours after death.
The Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier прletely (Check only one) ţ, 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 30434 Hotmanr 32. Aegistrar's Signature 31. Date filed (Month A) U 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** C. Friedlander 2010 2:45 p<sup>M</sup> August 26, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico 5973 Fire Fly Drive Salisbury 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Months 1170371925 Florida 135-22-1799 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exp. injury and the multiplical and once. 1 ☐ Yes 2 X No Director Wicomico Maryland Salisbury 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21801 USA 5873 Fire Fly Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: white 2 Specify: 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James M. Taylor Ruth Gannaway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Waddell/daughter 8094 Brown Road, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parsons Cemetery 9/1/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Achieway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Call K 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** andra (Mest MINT disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** /-1K5 Myo cardial lautin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transi Cardiolascular Stream Antervielentie Due to (or as a consequence of) Box 68760, Physician/Medical as the l 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached f □Yes 2 No P.0. 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ atrial Fibrillation 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∭Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director; completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier Emald M. Wow MD 110688

Registrar

State

400 EASTERN SHORE DK.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signati

Honald M. Wood

31. Date filed (Month

10-06650 Henry Grahan F	erre		<b>pe or Print</b> itate of Maryl							_	2016	2 2 2 2 2 1
		1- For State Registrar			ertificate c					reg. No.	2010	
Physicia Medical Exami			Henry Gra		r.				2. Date of D Month Septem	eath Day ber 3, 201	Year 10	3. Time of Death 1224 hrs
( )		4a. Facility Name (if not instituti 109 Gooseneck Coul	-	reet and number) 4b. City, Town, or Loca Elkton				ation of Deat	ation of Death 4c. County Cecil			h
Funeral Director		5. Social Security Number 221–40–5218	6. Sex	7. Age (In yrs.	5.5	If Under 1 Year   If Under 24Hrs Months   Days   Hours   Min			_	Birth (MM/DC	1 ^	rthplace (State or Foreigr ountry) St Virginia
		Usual Residence of Decedent	1 X XM 2 F	L	۸۱ در	S.			10/2	11/1/5	"""	
ow any		10a. State 10b. County  Maryland Cec		10c. City	y, Town or Loca Elkt							10d. Inside City Limits  1 Yes 2 No
aryland Ba-f sho at once	Director	Maryland Cec  10e. Street and Number	11.		EIKU	10f. Zip Code	e			10g. Citizer	n of What Cou	
ith the Maryland 23a or 28a-f show notified at once.		109 Gooseneck	Court			21921 United S						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 X Never Married 2 X N	Married Armed F	ecedent Ever in U Forces? 2 X No		as Decedent of Yes, specify Cul				No- 14	. Race - Amer White, etc.	ican Indian, Black,
s after d	by Fi		vorced If Yes, Give Ye or Dates:	ear		Yes 2XX						nite
72 hours		<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>		1-4 or 5+)		nt's Usual Dccu nost of working l				16b. Kind	d of Business/	Industry
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	17. Father's Name (First, Middle Ferrell Henry	, -,				18.N		e (First, Middle he <b>rin</b> e		,	
Should band Men is mar	٥	19a. Informant's Name/Relations	ship (Type, Print)			g Address (St						
B, MD and 2 sho dealth and item 27 is traumati		Karen Trosino  20a. Method of Disposition	·	20b.	Place of Dispo	Goosene sition (Name of	cemete				y Land ation - City or	21921 Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 XXBurial 2 Cremation 4 Donation 5 Other S		rom State No	crematory or of rth Eas thodist	t Unite Cemete	d rv		<sub>Date</sub> tember 2010			t, Maryland
Salti ermit. Departm mports njury o		21. Signature of Funeral Service	Licensee		22.1	Name and Addre	ess of F	acility Cr	ouch Fu	neral	Home	
Physician	$\dashv$	23a. Part I. Enter the disease, of	complications that	caused the death								aryland2190.  Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	a. Ather	cosclero		diovasc	cula	r Dise	ase			Between Onset and Death
		or condition resulting in death)  Sequentially list conditions,	Due to (or as a	a consequence of	of):							
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequence o	of):							
Mg. scuted	Examiner	(Disease or injury that initiated events resulting in death) Last		a consequence o	of):							
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8760 ificate b	J/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of preg		tal death	3 DE	ctopic pregna	incv		ate of delivery	y Day Year
Division of Vital Records, P.O. Box 68760, the Hospital or attending Physician: The law requires that the death certificate be exe thin 24 hours after death. The thin serificate has been signed by the attending physician ampletely filled in by the funeral director, page 2 should be deteched for use as the burial.	Physician/Medic	past 12 months?  1 Yes 2 No 9 Uni	4 Pregr	nant at time of de	aath —	her (Specify)				1410		ay real
O. B. nat the d and the d by the etzched		Part II. Other significant condit			resulting in the u	underlying cause	e given	in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
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Physician rethis ce	ပေါ	examiner? 1 Yes 2 No		Inpatient 2	ER/Outpatient		Othe		g Home 5		6 Other	: Scene
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death  1 X Natural 5 Pend	ding	of Injury n, Day,Year)	28b. Time of t		ijury at \  Yes :	Work? 2 No	28d. Describe	how injury o	occurred	
ivision or Atter der Directo	tifica	3 Suicide 6 Coul	a not be	e of Injury - At h	ome, farm, stree	et, factory, office	e buildir	ng, etc.	28f. Location or Town,		Number or Ru	ral Route Number, City
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To the H within 24 To the F complete	Medical	(Check only   Certifying Fr	hysician: To the bes miner:On the basis and manner s	of examination a								
	ž	29b. Signature and title of certifie	)r	-n .		29c. Licer	nse nun C.M.E.				signed (Mor	
	}	30. Name and address of person	who completed cau:	se of death (Item	n 23a)		>.I¥I. Ľ.	•		Septer	nber 4, 20	-
		Russell Alexander MD	Assistant M	ledical Exan	niner 111	Penn Stree	t, Bal	timore, MI	21201			
Sta Regista	ate rar	SEP 1 5 2010	Denov 32. Re	egi frar's Sichat	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			6	CME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29<sup>Day</sup> 20ÎÖ 15:42 Charles Roy Gilson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Atlantic General Hospital If Under 24 Hrs 5. Social Security Number 4**657** 183-22-4659 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. 8 2 1 / 1 9 2 8 Director 82 PA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Chincoteague VA Accomack 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 23336 Light House Landing 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 🗆 Yes 2 No Specify: If Yes, Give Year or Dates white 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Commercial Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances Dudley George Gilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 579 Jefferson Ave., Warminster, PA 18974 Charles Gilson / son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 9/3/2010 Warwick, PA Neshaminy Cemetery Signature of Funeral Service Lisenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a con equence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Year Month Day 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? Yes 2 X No 1 Yes 2 No Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) D0064120 8/29/2010 M·D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21811 Atif Zeeshan Aut 9733 Health Way Berlin Drive 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 35 GREEN Physician/ WILLIE 2010 OUISE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GROVE HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 2010 Months Hours Min 1 M 2 Director Usual Residence of Decedent 26 28a-f shov 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at within 72 hours after death with the Maryland Director MONTGOMERY VILLAGE MONTGOME AUGUST 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? STRAITH HAVEN DR. Funeral 20886 items 23a 20545 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married ò þ 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: BLACK "natural" Completed 3 Widowed 4 Divorced GREEN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry PRIVATE and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC FAMILIES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ HARRY W. GREEN MARY BROWN injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ル 🥏 💝 🖟 19a. Informant's Name/Relationship (Type, Print) (DAU) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 20545 STRAITH HAVEN OR MONTBOMERY VILLE 20c. Location - City or Town, State 20b. Place of Disposition (Name of Sino. cemetery, crematory or other place)

SMINUS BUR 6 CREM. 1 Burial 2 Cremation 3 Removal from State SEDT 11 2010 SMITHSBURG 4 ☐ Donation 5 ☐ Other (Specify) ROCCINSPEN. HEME 21. Signature of Funeral Service 22. Name and Address of Facility PREDEICE MO 21701 Coll 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner FAILURE TO THRIVE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi' Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown PULMONARY EDEMA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2: autopsy performed 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) n 24 hours after death.

ne Funeral Director: After the pleted filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending work 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier halane Rane MD D068178 AUGUST 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANTOSH RANE MEDICAL CENTER DRIVE ROCKVILLE 9901 MARYLAND

3. Time of Death

10d. Inside City Limits

Interval Betweer

Onset and Death

Day

2 Mo

Year

20850

Yes 2 No

9:35 AM

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 28950 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 5, Henry William Hamann 2010 1:05 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home St. Mary's Charlotte Hall . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Aug. 7, 1930 Director 578-38-0761 80 California Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland St. Mary's Mechanicsville 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 41170 Glenwood Place 20659 United States items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ò Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Year or Dates 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Airline permit. Page 1 and 2 should be filed very Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Hamann Grace Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma J. Hamann 41170 Glenwood Place, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sept. 8, Brinsfield-Echols Crem. Charlotte Hall, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARRHYTHMIA 'ARDIAC disease or condition Medical resulting in death) Examiner SENTIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Verthe 74 hours after death.

Verthe Funeral Director: After this certificate has been signed by the attending physician and Chripteted filled in by the funeral director, page 2 should be detached for use as the burnar-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MASCULAR ACCIDENT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🔲 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifie 29d. Date signed (Month, Day, Year) D0067788 9.7.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlotte Hall Rd, Charlotte Hall MD 2012

Registrar
DHMH 17 Rev 7/2009

State

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	<b>-</b>		Decedent's Name (First, Middle	e, <i>Last)</i>					2. Date of D	eath		3. Time of Death
	Physicia Medio		Ramon Jerome H	acker					Month 8/	22/201	10 Year	2pm M
	Examin	er	4a. Facility Name (If not institution	,			4b. City, Town, o	or Location of Death		4c. Co	ounty of Death	
- 20	Funeral		210 Norman Ave 5. Social Security Number	6. Sex 7. Ag	e (In vrs. la	st birthday)	G1er	Burnie If Under 24 Hrs.	8. Date of B		Anne Ar	undel place (State or Foreign
	Director		216-36-8739 Usual Residence of Decedent	1 🕅 M 2 🚟 F	72	Yrs.	Months Days	Hours Min.	2/247	1938	Coul	
	and show	ō	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
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·0	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	12. Was Decedent 8 Armed Forces? rried 1 ☒ Yes 2 ☐		.   13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	14.	. Race - Ameri Black, White,		
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Baltimore, Maryland 21215-0036	ge 1 and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation	3  Removal from State			sition (Name of natory or other plac	1 12-1-10			tion - City or Ti	
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	nysicia	ė il	Immediate Cause (Final disease or condition	A v. tr	· · · · · · · · · · · · · · · · · · ·	enla	notic	Hear	+ D	15 CA	نسريسا	Interval Between Onset and Death
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Ř	sician: The law r certificate has b irector, page 2 sl	Con							perfe	ormed?	death?	
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Division of Vital Records,	Attending Physician: The law requires that the death certificate be at death. After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the but the funeral director.	Certificate:	1 Natural 5 Pendin 2 Accident Investig	ng (Month, Day,	Year)	injury	28c. Injun work M 1		28d. Describe	how injury oc	ccurred	
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	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director After this or completed filled in by the funeral dir	Medical	(Check 2 Medical E	Physician: To the best of r xaminer: On the basis of ex	amination a	and/or investi	igation, in my opinic	on death occurred a	t the time date :	and place, and	d due to the car	use(s) and manner stated
	o the	ž	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the b	pest of my l	knowledge, d	eath occurred at the	e time, date and plac	ce, and due to the	ne cause(s) an	d manner as st	ated.
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U	H5H		William F	Jones		D	495	Amer	-1CB	0	110	<b>ラ</b> ゟ゙
	Stat Registra	_	31. Date filed (Month, Day, Year)  AUG 2 6	32. Fegistra	r's Signatu	1. b	all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Linwood Stokes Hall Physician/ Month 2010 11:20 P M August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1024 Tyler Avenue Annapolis Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y OCt. 24 **Funeral** 9. Birthplace (State or Foreign 1**XX**M 2 □ F 91 Months Days Year) 1918 214-05-2581 Maryland Yrs Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 □ No 10e. Street and Number ò 10f. Zip Code 10g Citizen of What Country? "natural", or items 23a o Funeral 1024 Tyler Avenue 21403 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1XXYes 2 □ No If Yes, Give Year or Dates. 1941–54 Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Completed 3 Divorced Specify the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Naval Academy Planner and Estimator 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edgar Linwood Hall Emily Elizabeth Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Lois Hall/wife 1024 Tyler Avenue Annapolis, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State Baltimore Crematory 9/5/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a cons x uence of) **Examiner** Esquentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Vear 2 No the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24 hours after death. e Funeral Director. After this certificate has been. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 W No 25. Was case referred to dica examiner? æ 26. Place of Death (Check only one) Hospital 2 No Other: ျင 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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DHMH 17 Rev 7/2009

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Registrar

only one) 29b. Signature a

31. Date filed (Month

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nd title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leon ski

32. Registrar's Signature

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3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

00054903

139 Old Solomons

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ France Felton Jordan, Sr. Ам September 4, 6:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death St. Mary's 43783 St. John's Road Hollywood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year June 13, 19 1 🛣 M 2 🗆 F Hours Country) North Carolina 239-46-3531 76 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Hollywood 10e. Street and Number 10g. Citizen of What Country? Funeral 43783 St. John's Road 20636 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry **Federal** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n College (1-4 or 5+) Elementary/Seconday (0-12) Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Percy Jordan Mozelle Black and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Jordan / Wife permit. Page 1 and 2:
Department of Health
Important: If item 27
any injury or other tr
once. P.O. Box 1322, Leonardtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 7. ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2010 Alexandria, Virginia 21. Signature of Funeral Service Ligen 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. fardiner P.O. Box 270, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Coronary disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Alzheimen Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 9 Unknown cate has been signed by page 2 should be detacl Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; A
completed filled in by the f Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12.4. Bun a Ge, m.J. 121893

State Registrar

DHMH 17 Rev 7/2009

32 Registrar's Signature

22335 Exploration , Suite 1035, Lexington Park, MD 20653

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roy H. Bunales, MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28954 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 29, 2010 Jordye Joy Judd 5:40 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Citizens Care & Rehab Center Frederick Frederick 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F 543-32-9322 77 Hours Min March 20, 1933 Nebraska Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1703 West 7th Street 21702 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White I and 2 should be filed within 72 hours afti f Health and Mental Hygiene. item 27 is marked other than "natural", 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Property Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Harris Jordan Edna Mae Woodworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curt Judd / Son 9730 Gas House Pike, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Auguste 30. 1 Burial 2 X Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 21. Signature of Fune Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 Catoctin mountain Hwy, Frederick. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit Exami executed that initiated events Due to (or as a consequence of) physician are sthe burial-t resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Year Day ed by the a detached f a ☐ Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has certificate ha 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 12 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1212,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24<sup>Day</sup> AUG STANLEY ANDREW JANET, SR. 2010 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 19705 BODMER AVE. MONTGOMERY POOLESVILLE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Min. 05/28/1931 207-24-1999 79 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY POOLESVILLE 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19705 BODMER AVE. 20837 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) l Hygiene. NEWSPAPER PUBLISHER Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED EDITOR 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MARY PUCH JOHN JANIEC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19705 BODMER AVE., POOLESVILLE, MD 20837 SOPHIE JANET / SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9/21<sup>D</sup>7<sup>to</sup>2010 ARLINGTON MATIONAL CEMETERY 1 Burial 2 Cremation 3 Removal from State ARLINGTON, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Betweer Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2 No signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed 2 🗌 No Yes 2 N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA nin 24 hours after death.

the Funeral Director: After thi

mpleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State

Registrar

To the within 2

Medical

29a. Certifier

29b. Signature and title of certifier

Box 68760

P.O.

Records,

**Division of Vital** 

DHMH 17 Rev 7/2009

James J. Gars, MD

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

VA - 010/229004 8901 Wiscorgin Ave.

Medical Examiner: On the basis of examination and/or investigation, in rry opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 33 am ARTHUR H. JOHNSON, SR. 2010 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death ty of Deat If Under 1 Year Birthplace (State or Foreign Country) Funeral Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth May 12,1929 Minnesota 1 😾 M 2 🗆 F Months Days Hours Min 470-26-1672 **Director** 81 May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 20a or 28a-f show ampoint or hother traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director MD Harford Bel Air 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 300 Sunflower Drive, Apt. 153 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1951 - 57 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Manager 12 Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Z. Johnson Ellen S. Anderburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21014 Elizabeth Lou Johnson/Wife 300 Sunflower Dr., Apt. 153, Bel Air, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crem. 9/4/2010 Leola, PA 22. Name and Address of Facility Signature of Funeral Service Lic Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications shock or heart failure. List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only nterval Between onset and Death Immediate Cause (Final Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown P.0 that the Part II.**,/Offner significant,conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 1 Yes Yes Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Vital Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending safter death. 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital or A City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

28957

9:10 A

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XYes 2 No

Maryland

Somerset

U.S.A.

14. Race - American Indian,

White

21901

Approximate Interval Between Onset and Death

21817

23d. Date of delivery

Day

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

Year

Month

2. Date of Death

**Physician** 

1. Decedent's Name (First, Middle, Last)

Registrar

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

29d. Date signed (Month, Qay, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) und M. MKIN. 201

32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elsie Dell Johnson 0754 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death nty of Death **Examiner** COMICO Medical (a) Calona 8. Dale of Birth (Month, Day, Year) 6-11-193 9. Birthplace (State or Foreign Country) VA If Under 1 Year **Funeral** 1 🗆 M 2 🗶 F 76 Director 4-30-9422 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 TyrYes 2 No MD Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 218<u>01</u> USA 1014 Queen Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc marked other than "natural", or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specif Black 3 Divorced 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 Seamstress Manhatten Shirt Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o မ <u>Rosetta Lewis</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2436 Knapps Way, Odenton MD 21113 <u> Antonio Johnson/Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other placem 20a, Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 8-30-2010 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature 917 W. Isabella St. Salisbury, MD 21801 Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 10 Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a conseque attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Yes 2 No g 🗌 Unknown been signed by the should be detached g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part \( \). 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed After this certificate 1 Yes 2 No Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident
Suicide s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - 'At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) within 24 hours a

To the Funeral D Medical 29a. Certifier 1 Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe Date signed (Month, Day, Year) 160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 CIVIC' AVENUE KODINS 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alan Jenkins Physician/ Bruce August 27, 2010 7:46 рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury 1309 Belmont Ave. Wicomico Social Security Number If Under 1 Year I If Under 24 Hrs. Funeral Sex 1 M 2 D F 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 212-40-9105 69 (Month Day Year) 09/17/1940 Maryland Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? items 23a 1309 Belmont Ave. 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Navy 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Year or Dates. Navy 3 Widowed 4 X Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) wood working trim carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Gertrude Bozman George Ethridge Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30275 Holly Lane, Delmar, MD 21875 Kathleen Jenkins/sister-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 8/31/2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Function Service Licensee

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1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? injury 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Whedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

When the cause(s) and manner as stated. 29a. Certifie (Check only one) 29b. Sid nature and title of certifie 29c. License number 31 10

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Division of Vital Records,

21801

wo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E

Carroll

Please Type or Print in Black Indelible Ink. Freyre All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 Amend #7 & #8 per Fun Dir AA Co. Health Dept 9/9/10 lo 28960 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Fusako Jacobs 2010 11:10P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8248 Mimico South Millersville Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Aug 26 1 □ M 2 🗓 F Hours Min. 339-36-8455 Director 63 Japan Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Millersville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 8248 Mimico South 21108 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: Japanese her than "natur t, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) al Hygiene. College (1-4 or 5+) 12th O Seamstress Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic even Kyozaburo Fudamoto t. Page 1 and 2 should be tment of Health and Mer tant; If item 27 is marke Chiyo Fudamoto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas E. Jacobs (Husband) 8248 Mimico South Millersville, Md. Department of Healt Important: If item 2 any injury or other t other i Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8-31-10 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. Signature of Funeral Service Licensee Winame Races cof Scilit Sons Mortuary, P.A. 821 West St. Annapolis, 1100883 Md. 23a. Part 1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause \_\_\_\_ch line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Ordenying Cause (Disease or linjury Due to (ar as a consequence of cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed Yes 2 death? 1 Tyes Be ( 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 2 X No ၉ 1 🗌 Yes this 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8/26/10 pleted cause of death (Item 23a) (Type, Print)

State

Registrar

AUG 2 6 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Brownie Jenkins August 26 2010 ear 10:05 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 505 Monticello Ave. Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Days Hours o*5%20%*1*92*7 Tennesse Director 215-20-2489 Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Directo 1 X Yes 2 ☐ No Maryland Wicomico Salisbury 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 505 Monticello Ave. 21804 USA items 2 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ō 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: "natural", white Specify: Completed 3 K Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) secretary Dresser Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Alfred Keith Beatrice Shaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Calvin Dr., Salisbury, MD 21804 Nancy Jenkins/sister-in-law 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wicomico, Memorial Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (SEME) OMBONICAL 8/28/2010 Salisbury, MD 21. Signature of Funeral Service 22H0110Way Funeral Home Professional Association ate n 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only be cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Fhysician/ disease or condition resulting in death) ALZHEIMERS DEMENTIA/DISEASE Medical Due to (or as a consequence of): Examiner FAILURE TO THRIVE Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of: ng physician and as the burial-transit that the death certificate be executed HYPERTENSION Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo ō 5 Other (specify) Month Year To the Hospital or Attending Physician: The law requires that the ceawithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50929 August 30, 2010 MA

State

31. Date filed (Month, Day, Year) SEP (11 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1405 S. Division St., Salisbury, MD 21804 Joy Madarang-Lewis, M.D. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mack Kellam, 2010 Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TENINSULA Kegional 3AUSBYM MAMICA If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year, 5 – 1 – 1 9 3 9 Birthplace (State or Foreign Country) . Age (In yrs. last birthday, **Funeral** 1 🔀 M 2 🗆 F 228-48-5346 Months Hours Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Worcester Pocomoke 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 720 Tenth Street, Apt <u> 21851</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Dever Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates SpecifBlack 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event; the Medic once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Production Carver Hall Labor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Mack Kellam, Sr Christine Manuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Trader/Daughter Ninth St, Pocomoke, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Westover, MD 19-4-2010 <u>Macedonia Mem Pk</u> 22. Name and Address of Facility 917 W. Isabella St. gnature of Fineral Service Licensee Bennie Smith Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final cell large Physician/ Melestalia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page 2 performed? death? 1 Yes 2 No this certificate within 24 hours a er death.

To the Funeral Director After this certific completed filled in by the funeral director, 25. Was case referred to medica examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 No မူ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar CARROLL

30. Name and apdress of person who completed cause of death (Item 23a) (Type, Print)

100

Registrar's Signature

OhRA

31. Date filed (Month, Day, Year)

D63199

St. Salisbury Ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	artment of H tificate of D			giene Reg. No.	10 2	8963	
			Decedent's Name (First, Middle, Last,	)				2. Date of Dea	ath		Time of Death	
	Physicia Medic		Ernie Lee	Modlin				Month August	29, 2	2010	9:20 PM	
	Examin		4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or	Location of Death		y of Death			
			Charlotte Hall Veter	ans Home		Charlot				. Mary's		
	Funeral Director		5. Social Security Number 6. Sec	x XM 2 □ F	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day January 7	, Year)	9. Birthplace Country) North Ca	(State or Foreign	
			239-26-4332 Usual Residence of Decedent		09			panuary /	, 1921	NOI LII Ga	IOIIIIa	
	f showed at	ţo	10a. State 10b. County		10c. City, Town or Loc	cation					nside City Limits	
	Man 28a- notifie		Maryland St. Mar	y's		Calif	ornia				1 ☐ Yes 2 ☒ No	
	ith the		10e. Street and Number	D 1- D	3	10f. Zip Code	619			What Country?		
	ems 2	=	24143 N. Patuxent	12. Was Decedent E	ver in U.S. 13. V	Vas Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-		ce - American In	ndian,	
ဖွ	or it	by F	1 ☐ Never Married 2 🖾 Married	Armed Forces? 1  Yes 2 □ N	f Yes, specify Cuba □ Yes 2 🎛 No		Black, White, etc.					
003	urs af tural" al Exa	ted	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.						White		
15-	72 ho n "na'	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give I	lent's Usual Occupa kind of work done o O NOT use retired)	ation luring most of work	ing	16b. Kind of E	Business Industr	у	
712	vithin jene.		Elementary/Seconday (0-12)	Callege (1-4 or 5-	+) ""6. 20	Barber			Ва	arber		
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ylaı	ld be Menta arked atic e	입	Joseph Gray	Modlin			Mittie E. Ange					
Nar	shou n and 7 is m raum		19a. Informant's Name/Relationship (Type	oe, Print)		ng Address (Street a			-		)	
e,	and 2 Healt em 2 ther 1		Juanita Modlin / W 20a. Method of Disposition	life	24143 20b. Place of Dispo	N. Patuxent		d, Califo		20619 - City or Town, 5	State	
nor	age 1 ent of nt: If ii y or o		1   Burial 2   Cremation 3   4   Donation 5   Other (Specify		cemetery, cren	natory or other plac		nber 3,		le, North		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. So rature of Fungral Service Line se		Modlin Ce	. Name and Addres						
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			23a. Par 1. Enter the disease, or comp shock, or heart failure. List only on	Cations that caused ne cause on each line	the death. Do not enter.	er the mode of dying	g, such as cardiac o	or respiratory an	rest,	Inte	oroximate erval Between	
	Pnysician/		Immediate Cause (Final disease or condition	a CARDI	AC ARF	MHTHM	IIA			Ons	set and Death	
	Medical Examiner		resulting in death)	1.00		RILLA						
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):	Ratti	14019					
	od d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	CONG	ESTIVE	HEAR	T FAI	LURE	_			
	execu an an	EX	resulting in death) Last		consequence of):							
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Box 687	ath certifica attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No	1 ☐ Live Birth : 4 ☐ Pregnant at	2 🗌 Fetal death 3 🛚	Ectopic pregnand Other (specify)	У			fonth Day	Year	
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/ita	siciar certif irecto	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ent 2 🗆 ER/Outpatie	Oth	ace of Death (Chec.		dense 6 1 Ot	hor (Specify)		
of \	g Phy er this ieral d	e: To	27. Manner of Death	28a. Date of injur (Month, Day	ry 28b. Time of		y at		now injury occur			
O	endin sath. or: Aft he fun	ficat	1 Natural 5 Pending 2 Accident Investigation		, rear) Injury	M 1 □	Yes 2 □ No					
Division of Vital Records,	or Attending Physician; The law requires that the after death.  Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str c. (Spec <i>ify)</i>	eet, factory, office		28f. Location (S City or Tow		ber or Rural Rou	ite Number,	
ō	pital ours a eral D		29a, Certifier 1 Certifying Phys	ician. To the hest of	my knowledge, death	nccured at the time	date and place, ar	nd due to the ca	use(s) and man	ner as stated.		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Examin	ner: On the basis of ex	xamination and/or investiges, best of my knowledge,	tigation, in my opinio	on, death occurred a	t the time, date a	and place, and d	lue to the cause(s		
	To the within 2 To the comple		29b. Signature and title of certifier			29c. License	e number		29d. Date sign	ed (Month, Day,	Year)	
			> Stumbac	)	MD	DOG	067788		8.	30.2	010	
, ex	mo		30. Name and address of person who c	ODALI	eath (Item 23a) (Type, I MD, 2944	Print) 9 CHARLOTTI	E HALL ROAL	, CHARLO	TTE HALL	, MD 20	)622	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 1 2	32. Registra	ar's Signature							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month McCabe M Jerome Michael 2010 30 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's California 23125 Winterberry Lane 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** <sup>Year)</sup>192<u>6</u> July 20, Hours 1 🗓 M 2 🗆 F 84 Maryland 220-12-9394 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 No St. Mary's California MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral United States 20619 23125 Winterberry Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) years U.S. Army Military Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Barbara Dement John Maria Joseph McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen M. McCabe/ Spouse 23125 Winterberry Lane California, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols Cre. 08/28/2010Charlotte Hall, MD 4 Donation 5 Other (Specify) 21. Signatura Muneral Solvice Lic asa Euward N. Brinstield 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval B. tween Onset au Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence o resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 🗌 Yes 2 🦃 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5  $\square$  Pending injury 1 🎒 Natural 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

BI

24035 Three Notch Rd., Hollywood, MD 20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

Registrar's Signatur

James P. Jarboe, M.D

31. Date filed (MontSPapYer) 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Lucy Scafide Mori <u>September</u> 2010 1:50 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours Washington, Director 88 04/01/192 578-22-4720 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland St. Mary's 1 🗌 Yes 2 😾 No Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 39528 Jarrell Drive 20659 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Tes 2 No Specify: Specify. 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Scafide Gasper Lucia Lombardo t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Michael Mori/Son 11811 Adrian Lane, LaPlata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Queen of Peace 09/11/2010 Helen, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARDIORESPIRATORY ARREST Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PERKALEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical LOW DEAL Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 s performed' 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Director: in 24 hour.
the Funeral Direc. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 D69683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Re

LEONARDTOWN MD

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		State of Manuaged / Don			€.
		State of Maryland / Dep	artment of Health and K rtificate of Death	2010	28966
		Registrar  1. Decedent's Name (First, Middle, Last)	tilleate of Death	Reg. No 2	3. Time of Death
Physicia Medic		Constance Lee Mitchell		8/29/2010 Day Year	
Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	
Funeral		22 Mist Flower Rd.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Berlin  If Under 1 Year   If Under 24 Hrs.	Worcester  8. Date of Birth 9. B	irthplace (State or Foreign
Funeral Director		222-18-2803 1	Months Days Hours Min.		ountry)
ld st	_	Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or Lo	cation		10d. Inside City Limits
arylan ia-f sh ified a	Director	MD Worcester Berlin	cation		1  Yes 2 Se No
the M or 28		10e. Street and Number	10f. Zip Code	10g. Citizen of What 0	
n with	Funeral	22 Mist Flower Rd.	21811	USA	
r deat or iten iner n		11. Marital Status  1 □ Never Married 2 🏝 Married  12. Was Decedent Ever in U.S. Ammed Forces?  1 □ Yes 2 🐒 No	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.) 14. Race - Am Black, Wh	nerican Indian, ite, etc.
's afte ral", c Exarr	ed by		1 ☐ Yes 2💢 No Specify:	Specify: wh	ite
2 hou "natu edical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki	16b. Kind of Busines	s Industry
ithin 7 ene. r than	Com	Elementary/Seconday (0-12) College (1-4 or 5+) life. D	O NOT use retired) C	Montgomery	Co. Schools
filed wall Hyg	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
Menta	욘	Anthony Joseph Maio	Margaret	Clementine Stepro	
permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ng Address (Street and Number or Rura L <b>ower Mist Rd. Ber</b>		Zip Code)
1 and f Heall item 2 other		20a. Method of Disposition 20b. Place of Dispo	sition (Name of	Date 20c. Location - City of	or Town, State
Page nent o ant: If iry or		1 Dullar 242 Gernation 3 Li Nellova non State	natory or other place) Lopen Crem. 8/30/		
permit. Departn Imports any inju			Name and Address of Facility The		
<u>0</u> 0 <b>= 0</b> 0	_				
Discontinuo (		23a. Pay I fer the disease, or complications that caused the death. Do not ent so or heart failure. List only one caus on each line.  Imm: liate Cause (Final	1		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)  a.   **Tue to (or as a consequence of):**	1-DONOCAZ CINI	m4	
Examiner	_	Sequentially list conditions, b. LUNG CANCET	K .		
sit sit	Examiner	if any, leading to immediate Que to (or as a consequence of):	LOENO CAPLECNOM	A	
be executed sician and burial-transit	Exar	Cause (Disease or linjury that initiated events resulting in death) Last c. Due to (or as a consequence of):	12-1-1011	,	
e be e; ysiciar e buriz	lical	<b>L</b> d.			
or Attending Physician: The law requires that the death certificate is after death.  Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE:			
ath cel attend for use	cian/	In the past 12 months?	Ectopic pregnancy Other (specify)	23d. Date of d Month	elivery Day Year
t the dea by the a tached	hysi	1  Yes 2 No 4 Pregnant at time of death 5 L 9  Unknown 9  Unknown	Other (specify)		
that tyned by	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribute	
v requires that s been signed t should be det				1 🗆 Yes 2 🗀 No 3 🗆	Probably 4 Unknown
The law recate has be page 2 sh	Completed				utopsy findings available completion of cause of
i <b>ician:</b> The certificate rector, pag		25. Was case referred to medical	26. Place of Death (Check	1 Yes 2 No 1 Yes	es 2 🗆 No
ysician: is certific director,	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	- Other:	me 5-Residence 6 Other (Spe	ecify)
ing Phys ifter this		27. Manner Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred	
ttendi death stor: A / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	000 1	1. T. T. T. T. T. T. T. T. T. T. T. T. T.
al or A s after I Direct d in by	S	4 ☐ Homicide determined building, etc. (Specify)	set, factory, office	28f. Location (Street and Number or R City or Town, State)	urai Houte Number,
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inves	occured at the time, date and place, an	d due to the cause(s) and manner as s	tated.
thin 24 thin 24 the F	≥	only one) 3 Certifying Nurse Practioner: To the basis of examination and/or investigation only one) 3 Certifying Nurse Practioner: To the best of my knowledge, of 29b. Signature and title of certifier	death occurred at the time, date and place	e, and due to the cause(s) and manner a	s stated.
<b>5</b> • • • • • • • • • • • • • • • • • • •	- 1		29c. License number	29d. Date signed (Mon	
<b>,</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, F ED WZN OSMERA WID)	Printy	-10	0-1014
5			for oceance	7 BUD. DEKUN	MJ 2/8/1
Stat Registra	e 1	31. Date filed (Month, Day, Year) AUG 3 0 2010  32. Pegistrar's Signature	. 4. 1	<del></del>	
negistra		power p. go	ure .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8/27/2010 Pay Physician/ 8:48 A Dale William McRoberts Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Atlantic General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**x**□ M 2 □ F 9/5/1952 Director Yrs MD 57 219-60-1430 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director ~219-60-1430 1 🗌 Yes 2 🗎 No MD Snow Hill Worcester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral USA 21863 7728 Cedartown Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Worcester Co. Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wanda Hastings Paul Leslee McRoberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7742 Cedartown Rd Snow Hill MD 21863 Heather McRoberts (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriai 2 Compation 3 Removal from State 4 ☐ Doyation S ☐ Offred (Specify) Cape Henlopen Crem. B/30/2010 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral 2007 oബ icensee 108 William St. Berlin, MD 21811 23a. Part . Entermine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed te Cause (Final diseas or condition resulting in death) halopath Physician/ Medical Due t (or as a consequence of): Examiner Sequentially list conditions, if any analog property cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consuluence of that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending within 24 hours are: \_\_\_ Aft

To the Funeral Director: Aft

-\_\_\_lated filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 [ 29b. Signature and title of o 29d. Date signed (Month, Day, Year) 29c, License number

Registrar DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print

31, Date filed (Month, Day, Year)

**AUG 30** 

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thorny Dr Berlin MD 21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended #28F per MD, RG FCHD 8/31/10 Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CECILIA MARY MARYMAN Medical August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick
If Under 1 Year If Under 24 Hrs. Frederick 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day an. 28 1 🗆 M 2 🔀 F Months Days Hours Min 200-20-1304 83 <sup>Year)</sup>927 Director Jan. Usual Residence of Decedent 28a-f show the Maryland 10a. State 10c. City, Town or Location Funeral Director Examiner must be notified Md. Carrol1 Mt. Airy 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 713 Midway Avenue 21771 United States Page 1 and 2 should be filed within 72 hours after death in ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items jury or other traumatic event, the Medical Examiner mi Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Dempsey Shea Evelyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod Jean M. Lanham / Daughter 402 Deer Hollow Drive, Mt. Airy, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ortant: If it injury or o 1 M Burial 2 Cremation 3 Removal from State Department Important: If any injury or once. Gate of Heaven Cem. 9/01/10 Silver Spring, Md. 4 Donation 5 Other (Specify) <sup>22</sup> Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5<u>038</u>, Laytonsville Signature of Funeral Service 21. -00470 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as)a consequence of) -transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical Box 68760 IF FEMALE: To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Dolo

9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

11:06 P M

9. Birthplace (State or Foreign Country)
Washington, D.C

20882

Day

1 Yes 2 No

Year

Approximate Interval Between

Onset and Death

10d. Inside City Limits

1 Yes 2 No

DHMH 17 Rev 7/2009

State

Registrar

Dr. Margaret Daramola

AUG

31

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AMBARAMA.

Address of person who completed cause of death (Item 23a) (Type, Print)

Margaret Daramola 400 W. Seventh Street, Frederick, Md.

400

Varket

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Phyllis MacWilliams 2010  $P^{M}$ 1:50 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 193–32–0247 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 245XTF 68 Months Days Hours (Month, Day, Ye Director 1942 Feb. Pennsylvania Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c, City, Town or Location Director Maryland Annapolis Anne Arundel 1 Yes 2 X No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country?  $U_{\bullet}S_{\bullet}A_{\bullet}$ 1516 Enyart Way, Unit 304 21409 Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black White etc þ 1 Never Married 2 XXMarried 1 Yes 2XXNo Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " within 7 College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education th and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname)
Sue Politz 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 Philip Kovalcik 19a. Informant's Name/Relationship (Type, Print)
Alvin MacWilliams/husband 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1516 Enyart Way, Unit 304, Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 9/4/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Respiratory Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami physician and s the burial-transit Physician: The law requires that the death certificate be executed ronic. obstructive Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 Yes 2 No 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A: completed filled in by the fu Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check nd title of certifier 29d. Date signed (Month, Day, Year) 2010 D60390 MEDICAL HOSPITALIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jaher Annapolis Arundel Medical Center 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Maryland 21215-0036

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2010 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 37 M JAYNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ENTER ST. NEN! If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Year Hours Min. Days 1 1 M 2 □ F 546 25 3940 Usual Residence of Decedent Yrs OLORADO **Director** 10d. Inside City Limits 10a. State 10c. City, Toward Location 28a-f show 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 'natural", or items 23a Funeral ENTER 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates 31 \_ 84 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑No Specify. þ 3 ☐ Widowed 4 ☑ Divorced ハコモ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) CORIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental I ant: If item 27 Is marked of CAROL A. MADSE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health important: If item 27 I PAGATENAMO. 21122 SCORTON HARROX K MADSEN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -10-10 4 ☐ Donation 15 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DAUGHERTY FUNERAL HOME 400942 2601MOUNTAIN RD. PASADENA, MD 23a. Part 1. Enter the discrete, or complicates at lat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairle. List Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 3 Probably 4 Unknown 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**⊠**Ño 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

P.O. Box 68760 Records. Vital Division of A hours after decreeral Director: A' Nothin 24 hours after unitable to the Funeral Direct

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Harrison Mr

15 2010

29c. License number

29d. Date signed (Month, Day, Year)

Marshalee Dr. Elknidse MD 20075

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 3:37 Helena C. Macintire August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** (Month, Day, Year) 06/16/1940 1 □ M 2 😾 F Months Days Hours Country) Director 70 217-38-2139 Delaware Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21204 4 Bardeen Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Elementary Education Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Gould Macintire Helena Maull Coverdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George G. Macintire / Brother 65 Sussex Drive, Lewes, DE 19958 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Eastern Shore 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/24/2010 Lewes, DE Crematorium 21. Signature of Funeral Service Li 22. Name and Address of Facility
Parsell Funeral Enterprises, Inc. 6961 Kings Highway, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia with hypoxia and hypercarbia Ph sician/ Community Acquired nenous disease or condition Medical resulting in death) Examiner Rupsel Ventricular Response Filmilation with unkurun Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No been signed by the atter should be detached for Dav Pregnant at time of death 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Domentia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Schizophrenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the lirector, page 2 s autopsy 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: ဂ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 1 Natural Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours after Funeral Direc determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Funer completed fil 3 \_ Certifying Norse Prantioner To the best of my knowledge, death upro med at the time, date and place, and disk to th 29b. Signature and title of certifier seenawalt D0060248 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore, MD JC Greenawall MD 6701 Norm Charles Street 31. Date filed (Month, Day, Year) Registrar

a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ August Marchant Morrish 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery <u>Silver Sprinc</u> Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Dec 13, 1916 1 M 2 XF Hours Min. 362-09-2277 Michigan Director 93 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 X No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17340 Quaker Lane 20860 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۾ ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: "natural", Completed 3 ★Widowed 4 □ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Brokerage Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Shivas Edna G. Van Tifflin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Morrish/son Reservoir Road Fulton, Maryland 20759 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Journey Crematory 8/25/2010 Woodbine, Maryland . Signature of Funeral Service Lic <sup>22</sup> Name and Address of Eacility Going Home Cremation Service P.O. Box 784 Himas M00957 mile Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Fluid Overload Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Pneumonia burial-tran Due to (or as a consequence of): physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🔀 No Other: မ 1 Xinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Tyes 2 D No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Box 68760 P.O. Records, Hospital or Attending Physician: **Division of Vital** 24 hours

the Funeral Director: After that pleted filled in by the funeral

State Registrar

(Check

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila Khan 1500 Forest Glen Road

32. Registrar's Signature

neur

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Silver Spring, Maryland 20910

29d. Date signed (Month, Day, Year)

August 24, 2010

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G907, 9/15/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUDITH LYNNE O'DONNELL SEPT 2010 11:07A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 12870 EDELEN ROAD CHARLES BRYANTOWN Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, NOV • 8 1 M 2X5X Months Days Hours Min Year) 1944 578-58-0486 Director 65 WASH Usual Residence of Decedent show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits **Funeral Director** 1 🗌 Yes 2 🔀 No MD CHARLES BRYANTOWN 10f. Zip Code Street and Number 10g. Citizen of What Country? 12870 12780 EDELEN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2√☐√No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY DEPT. OF TRANSPORT other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ပ JOSEPH JOHNSTON LUCILLE BURNS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREAT SHARON REYNOLDS NIECE 12870 EDELEN ROAD BRYANTOWN, MD 20617 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) METROPOLITAN CREMATORY 9-8-10 ALEX., VA. Signature of Funeral Service Licenses 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ hronic ISERS disease or condition Medical resulting in death) **Examiner** ICOTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ☐ Live Birth 2 ☐ Fetal deat☐ Pregnant at time of death in the past 12 months?
1 Yes 2 No Day Month Year 1 Yes 2 1/2 9 Unknown been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate 2 🗌 No 1 🗌 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Assider 5 Pending work 1 Tes 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 2 Medical Examiner: On the basis or examination arror investigation, in my opinion, was a country and the cause (s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 36506 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 AK R 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar rack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Joseph Earl Padgett 28, 2010 10:32 A M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 16715 Teagues Point Road Hughesville Charles 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 216-38-6230 Director May 25, 1941 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Medical Examinar must be notified at Maryland Charles Hughesville Director 1 ☐ Yes XX No 10e. Street and Number 16715 Teagues Point Road 10f. Zip Code 10g. Citizen of What Country? 20637 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian. 1 ☐ Never Married 21 Married 1 ☐Yes 2X No Specify Specify: White ₽ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter Government ĺ2 17. Father's Name (First, Middle, Last) Lemuel J. Padgett 18. Mother's Name (First, Middle, Maiden Surname) Be Beulah C. Steinhice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a Mary Ann Padgett/Wife 16715 Teagues Point Rd., Hughesville, MD 20637 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cem. 2, 2010 4 ☐ Donation 5 ☐ Other (Specify) Bryantown, Maryland 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service 30195 Three Notch Road, Charlotte Hall, MD 20622 -M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** SOC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) attending physician Physician/Medical as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the detached g Unknown g Unknown ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed been Was an autopsy performed? 24b. We're autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To . Date of Injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined

P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; A filled in by the

State Registrar

Medical

4 ☐ Homicide

(Check only

29b. Signature and title of certifie

29a. Certifier

0

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deficientlying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deficientlying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

Registrar's Signatur

and manner stated.

			For State of Maryla	_			Mental Hyg	giene	0 28976			
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	Death	Т	reg. No:				
	Physicia	n/		11 0			2. Date of Dea Month	Day Y	3. Time of Death			
	Medic Examin		Richard Ignatius Russe  4a. Facility Name (if not institution, give street and number)	11, Sr		Location of Death	<u>August</u>	31, 2010 7:30 PM				
	Examini	eı	22305 Gore Street			nardtown		1 1	Mary's			
110	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	n g	l. Birthplace (State or Foreign			
	Director		216-40-5014 1 ⊠ M 2 □ F	85 Yrs.	Months Days	Hours Min.	(Month, Day November		Maryland			
	d tt	_	Usual Residence of Decedent  10a. State 10b. County 10c. C	ity, Town or Lo	cation				10d. Inside City Limits			
	arylar a-fst fied	Director		nty, form of Lo.		1			1 🗆 Yes 2 🖾 No			
	or 28 noti		Maryland St. Mary's		10f. Zip Code	ardtown		10g. Citizen of Wha				
	with t	eral	22305 Gore Street		20	0650		USA				
	tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U		Vas Decedent of Hi	spanic Origin? (Sp	pecify Yes or No-	14. Race -	American Indian,			
စ္တ	fter d ", or i amin	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	I	f Yes, specify Cuba □ Yes 2 🔯 No		o Rican, etc.)		White, etc.			
ğ	ours a turali al Ex	Completed	3 ☑ Widowed 4 ☐ Divorced Year or Dates.						White			
5	72 hc n "na Aedic	nple	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa kind of work done d O NOT use retired)		king	16b. Kind of Busir United	ness Industry . <b>States</b>			
7	vithin liene. er tha the l		Elementary/Seconday (0-12) College (1-4 or 5+)		Budget	Officer		Govern				
פַ	il Hyg I Othe vent,	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, I	Maiden Surname)				
Maryland 21215-0036	d be denta	ī	William Lee Russell			Kath1	een Ann	Abell				
lar.	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a	and Number or Ru	ral Route Number,	City or Town, State	State, Zip Code)			
e oî	and 2 s fealth a		Robert S. Russell / Son			ottom Ro		ywood, M				
Baltimore,	ge 1 and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		natory or other plac		Date ember 3,	20c. Location - Cit	ty or Town, State			
ᆵ	it. Pa intmel intant injury		4 Donation 5 Other (Specify)		Xavier Ceme	Lery   20:	10		Maryland			
Ba	permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr once.	- 28	Wellneth Standine	22	. Name and Addres	P.	0. Box 270	, Leonardto	neral Home, P.A. own, MD 20650			
			23a. Part (. Enter the disease, or complications that caused the dec shock, or heart failure. List only one cause on each line.	ath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between			
	Physician/	8 8	Immediate Cause (Final disease or condition		Onset and Death							
	Medical Examiner		resulting in death)  Due to (or as a consecutive form)	quence of):	CJ	~						
		-e	Pascular result instruction control is,	su) re	1 500	1059						
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ROX	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	1 Yes 2 No 4 Pregnant at time of 9 Unknown	f death 5	Other (specify)			Month	Day Year			
Ö.	The law requires that the ate has been signed by the page 2 should be detach	/ Ph	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?			
ა. 7.	signe d be	d by	Hyper lined em	2			1 □ Y	es 2 No 3	Probably 4 Unknown			
Vital Records,	requ been shoul	lete					24a. Was a	n 24b. Wer	e autopsy findings available			
ပ္	ne law e has age 2	Completed				_	autop: perfor	sy prio dea	r to completion of cause of th?			
Ē	an: The tifficat tor, pa	Be C	25. Was case referred to medical		26. Pla	ace of Death (Chec	1 L Yes	2 L No 1 L	Yes 2 No			
<u> </u>	ysici is cer direc	To B	examiner? 1	☐ ER/Outpatien	t 3 🗆 DOA Othe	er: 4  Nursing H	ome 5 Reside	ence 6 Other (S	Specify)			
Ö	ng Ph fter th ineral		27. Manner of Death 28a. Date of injury (Month, Day, Year)  28 a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work		28d. Describe ho	w injury occurred				
0	tendi Jeath. tor: A the fu	ifica	2 Accident Investigation	<u> </u>		Yes 2 No						
Division of	or At after d Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At I building, etc. (Speci	nome, farm, stre <i>fy)</i>	eet, factory, office		28f. Location (St City or Town		r Rural Route Number,			
<b>a</b>	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2.	edical	29a. Certifier 1 Certifying Physician: To the best of my know	wledge, death o	occured at the time,	date and place, a	nd due to the cau	se(s) and manner a	s stated.			
	he Ho in 24 l he Fu	Med	(Check 2 Medical Examiner: On the basis of examinationly one) 3 Certifying Nurse Practioner: To the best of r	on and/or invest	igation, in my opinio	n, death occurred a	at the time, date an	nd place, and due to	the cause(s) and manner stated.			
	To t To t		29b. Signature and title of certifier	26	29c, License	number	06	29d. Date signed (N	log(h, Day, Year)			
			folia Des-be	_ ")	1/	5		9/0/	2010			
es.	رق		30. Name and address of person who completed cause of death (Ite		· ·	Maabaa	arr#11 - 1	MD 20450				
,-	Stat	e	Leon Berube, M.D., 28170 Old 31. Date filed (Month, Day, Year) 32. Fegistrar's Sign			nechanic:	sville,	עניז ∠טסטאַ עניז				
	Registra		SEP 0 2 2010 Senera	B. 4	arle							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Registrar	State of M	aryland /		artment of F			1	2010	28977
DI		Decedent's Name (First, Middle, Last	;t)			indute of L		2. Date of De			3. Time of Death
Physicia Medic		Laura Agn		hardso	n			Month Septem	ber	8, 2010	3:28 p. M
Examin	er	4a. Facility Name (if not institution, give 13301 Croom Road		Location of Death Marlbord		1	County of Death	orge!s			
Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	g. Birthr	olace (State or Foreign
Director		220-42-1506 Usual Residence of Decedent	□ M 2 <b>X</b> F	65	Yrs.	Months Days	Hours Min.	(Month, Da 11-27	-194	4 Mar	yland
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importantarit if them 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State 10b. County		10c. City, To	wn or Loc	eation	_			1	10d. Inside City Limits
	Director	Maryland Prince	Feorge's	Uppe	r Ma	r1boro	-				1 ☐ Yes 2 💢 No
	ralD	10e. Street and Number 13301 Croom Rd.				10f. Zip Code	0		-	tizen of What Cour	itry?
ems 2	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S.	13. V	2077: Vas Decedent of H	ispanic Origin? (St	pecify Yes or No-		JSA 14. Race - Americ	an Indian,
ifter de ", or it amine	þ	1 Never Married 2 XMarried	Armed Forces? 1 ☐ Yes 2XX If Yes, Give	No	- 1	Yes, specify Cuba		o Rican, etc.)		Black, White, Specify: Whi	
atural	eted	3 Widowed 4 Divorced	Year or Dates.	1 10		ent's Usual Occup			-		
in 72 h e. nan "n Medi	Completed	(Specify only highest grant Elementary/Seconday (0-12)			(Give k	ind of work done of NOT use retired)		king	100. K	ind of Business Ind	Justry
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be file ental H ked of c ever	To B	17. Father's Name (First, Middle, Last)  Henry Lawrence	Ruckler S	ir.			18. Mother's Nar	ne <i>(First, Middle,</i> cet Rose			
hould and Me s mar umati		19a. Informant's Name/Relationship (T			9b. Mailin	g Address (Street				Town, State, Zip (	Code)
nd 2 s ealth a m 27 i		Cheryl A. Farre	11/Daughte	r 1	5506	Baden Na	aylor Rd	, Brand	ywin	e, MD 20	613
ge 1 an nt of H. : If iten or oth		20a. Method of Disposition 1	Removal from State	ceme	tery, crem	sition <i>(Nam</i> e of natory or other plac		Date		ocation - City or To	wn, State
artmer artmer ortant injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lioens		Resur		ion Cemet				nton, MD	
Dep any		Tank Cles	// //-	M00817	30	Brinsfie 0195 Thre	ľď-Échols ≥e Notch	Funera Rd., Ch	l Ho arlo	me, P.A. tte Hall	, MD 20622
hysician/ Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)		). (	lus	r the mode of dying	•	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	a consequenc	e of):						
e be executed ysician and ie burial-transi	dical Exar	that initiated events resulting in death) Last	C. Due to (or as a	a consequenc	e of):						
g phys	Nedic		d								
To the hospital or Attending Priystcian: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal de		Ectopic pregnand Other (specify)	;y			23d. Date of delive Month	ery Day Year
uires tnat t n signed b uld be deta	by	Part II. Other significant conditions of	ontributing to death b	ut not resultin	g in the ur	nderlying cause giv	en in Part I.			use contribute to th	ne cause of death?
ine law req ate has bee page 2 shou	Completed							24a. Was auto perfo 1 \(\sum \) Yes	osy ormed?	prior to co death?	psy findings available mpletion of cause of
cian: 1 ertifica ector, p	Be C	25. Was case referred to medical examiner?	112-1				ace of Death (Chec		2 - 100	5 12 100	
rnysii this c	은	1 Ves 2 No  27. Manner of Death	Hospital:  1  Inpatie  28a. Date of injur	ent 2 ER/	Outpatien		4 ∐ Nursing H			Other (Specify	)
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al or Atter s after dez l Director d in by th	Certificate:	3 Suicide 6 Could not b 4 Homicide determined		ıry - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (\$ City or Tow		d Number or Rural )	Route Number,
Funeral eted fille	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of ex	xamination and	d/or investi	igation, in my opinio	on, death occurred	at the time, date a	and place	, and due to the car	use(s) and manner stated
within 3 within 5 comple	Σ	only one) 3 Li Certifying Nurs	se Practioner: To the	est of my kno	owiedge, d	29c. License		ace, and due to th		s) and manner as state signed (Month)	
Va		30. Name and address of person who d	ompleted cause of de	eath (Item 23a	a) (Type, Pr	rint)	, , ,		1	1	

State Registrar DHMH 17 Rev 7/2009 Harvey I. Katzen

8926 Woodyard Rd., Clinton, MD 20735
32. Regitrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 6 2010 Eugene Allen Reynolds, Sr. 0042 ΑМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Ceci1 Union Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** AUG 22, Year 932 1 🗶 M 2 🗆 F Maryland 219-28-7576 78 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 ី No Maryland Ceci1 E1kton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Hillcrest Court 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1950 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Armed Forces? 1950.

1 X Yes 2 No. 1953.

If Yes, Give
Year or Dates. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cable Splicer Telephone Be Department of Health and Department of Health and Mental Hy. Important if item 27 is marked office any injury or other traumatic once. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Coudon Reynolds Mary Belle Heverin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna C. Reynolds/Wife 24 Hillcrest Court, Elkton, MD 21921 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ilpin Manor lemorial Park 1 f X Burial 2  $f \square$  Cremation 3  $f \square$  Removal from State September 4 Donation 5 Other (Specify) 2010 Elkton, MD 22. Name and Address of Facility 21. Signati e of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Sea Physician/ disease or condition resulting in death) Oronar Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Kes 2 No 3 Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes 1, Enpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1 × Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tij 29d. Date signed (Month, Day, Year) 30-Name and address of person who completed cause of death (Item 23a) (Type, Prince

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04 OV M HIE K Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis 3504 Saratoga Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 459-36-7087 1 □ M 2 ☑ 84 Months Hours Country) Texas 4971791 926 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 25a or 28a-f sho amportant injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Anne Arundel Maryland 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21403 3448 Newport Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 

XYes 2 □ No Specify: Specify: Caucasian Mexican Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Administrative Assistant Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paula Hernandez Albert Guerra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 Saratoga Avenue, Annapolis, MD 21403 Genny Mejia - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 8/26/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee John M. 22. Name and Address of Facility Taylor Funeral Home Myclin T. 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont Cause (Disease or linjury the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29a. Certifier (Check 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certif signed (Month, Day, Year) 438 naleted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month

NTA

32. Røgistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North West Hospital Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 🗆 F Hours Yrs 53 Director 214-66-8171 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits: Director 1 Yes 2 No Caroline MD Preston 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Bethlehem Road 6071 21655 USA within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify:Black Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Pro-Temps Co. Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Copper Lillie Pearl Redd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Sandra Redd/Wife 6071 Bethlehem Road, Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Bethel 9-4-2010 Cemetery Cambridge, MD Funeral Service Licenses Bennie and Address of Facility 917 W. Isabella St. Salisbury, MD 21801 Funeral Home disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the a 1 Yes 2 L 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 2 🗌 No 1 Yes Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this Within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural Accident 5 Pending work 1 Yes 2 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Da

Box 68760

P.0.

Records,

Division of Vital

ss of person who completed cause of death (Item 23a) (Type, Print)

2010

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien ()

				partment of Health and leartificate of Death	Mental Hygien	<b>2010 28981</b>					
			Negistrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death					
	Physici		JOANNA KAY SHORT		Month D	7 2010 4:50 A. <sup>M</sup>					
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl		c. County of Death					
-			FROSTBURG VILLAGE NURSING HOME	FROSTBURG		ALLEGANY					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)					
	Director		235–30–0551 TLIM 2 XF 84 Yrs.  Usual Residence of Decedent		04/12/1926	WEST VIRGINIA					
	land ow It		10a. State 10b. County 10c. City, Town or	_ocation		10d. Inside City Limits					
	Mary -f sh fied a	ţō	WV MINERAL KEYSER			1 √2 Yes 2 □ No					
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?					
	h witl 23a o st be	a D	500 CARSKADON ROAD	26726	-	U.S.A.					
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	Specify Yes or No-	14. Race - American Indian, Black, White, etc.					
36	orit	٦.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 □Yes 2 □No Specify:		Specify:					
21215-0036	within 72 hours after death with the Marylan sien. Jenn. d by	3 ☐ Widowed 4 🔏 Divorced Year or Dates:		101	WHITE						
5	"nat	Completed	(Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of wor . DO NOT use retired)		Kind of Business/Industry					
212	withi iene. <b>thar</b>	E O	Elementary/Secondary (0-12)   College (1-4or 5+)	AITRESS		RESTAURANT					
D	be filed within 72 hours after death with the Maryland Hygiene.  Independent than "natural", or items 23a or 28a-f show et other than "natural", or items 23a or 28a-f show event, I'm Mariteal Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide						
Maryland	should be filed nd Mental Hygi marked other Imatic event, I	To B									
ar	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type. Print)	iling Address (Street and Number or Ru	ural Route Number, City	or Town, State, Zip Code)					
	and 2 ealth n 27 i	١.,		6 Dogwood Hill Roa	id, Barton,	MD 21521					
Ψ	- I b ≠		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Dis	position (Name of ematory or other place)	Date 20c.	Location - City or Town, State					
Ē	Pages ment of tant: If its jury or o		4 Donation 5 □Other (Specify) WVU Memo	rial Vault   09/0	08/2010 Mo:	rgantown, WV					
Ball	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	J Human Gif	t Registry					
_	<u> </u>		Total for disars	PO Box 9131, Morga	intown, WV	26506					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death					
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ny byense	-ent st	If yes					
,	Examiner		Due to (or as a consequence of):	×1							
		ē	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that billioned sentences of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the								
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Š R	attenc attenc for us	ian/		Ectopic pregnancy		23d. Date of delivery  Month Day Year					
<b>o</b>	he de	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	□ Other (specify)							
<b>7</b> .	that t	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?					
Hecords	quires n sigr ald be	d by	the pertension		1 ☐ Yes	2 □ No 3 □ Probably 4 □ Unknown					
ဝ္ပ	w rec s bee	lete	11		24a. Was an	24b. Were autopsy findings available					
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VITAI V	an; rtifica tor, p	Be C	25. Was case referred to medical	26. Place of Dea	1 □Yes 2 2 4 ath (Check only one)	lo 1 □Yes 2 □No					
>	nystci lis ce direc	To B	examiner? 1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpati	Lou	lome 5 ☐ Residence	6 ☐ Other (Specify)					
,   	ng Pr fter th	L:uC	27. Manner of Death  1. □ Natural 5 □ Pending (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)  28b. Time Injury	of 28c. Injury at	28d. Describe how inj						
DIVISION	endil eath. or: A the fu	Satic	2 Accident investigation	M 1 □Yes 2 □ No							
Ë	or Att fter de frect irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)					
ָ ב	pital o		29a, Certifier *** Certifying Physician: To the best of my knowledge, de	Market and the Property of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Contr							
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	to the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)					
	71-0			021266	0	9/7/2010					
			30. Name and address of person who completed cause of death (tem 23a) (Type	e, Print)		11110010					
			JESUS IRA, M.D 4 Bready	ray trostbur	9, MD	2/532					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regionar's Signature	Land !							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Year STELLA RILEY SIMPSON 5:20 PM 010 Medical Facility Name (if not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death PLATA ENTER harle If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖵 F Days Min. 9 Month Day (9ar) 5 Months WASH., D.C. 579-14-4601 94 Yrs. Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD. CHARLES NANJEMOY 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8255 GILROY ROAD 20662 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: WHITE "natural", Completed 3 X Widowed 4 ☐ Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10th OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events. ္ဝ JOSEPH RAYMOND LARE LILLIAN BEATRICE MARION 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAYMOND SIMPSON-SON 8295 GILROY RD. NANJEMOY, MD. 20662 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 9-10-10 SUITLAND, MD. 4 Donation 5 Other (Specify) Signature of uneral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X**No Other: ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at work?
1 \quad Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760

State Registrar

Medical

Natural

4 Homicide

29a. Certifier (Check

29b. Signatu

only one

Accident
Suicide

5 Pending

and title of certifier

2

Investigation 6 Could not be

determined

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

thin 24 hours after death.

the Funeral Director: A

within 2 To the I

injury

🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Signature

2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

28f. Location (Street and Number or Rural Route Number.

29d. Date signled (Month.

City or Town. State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar			Cei	rtificate of	Death		Reg. No		205	183		
nysiciar		1. Decedent's Name (First, Middle, L.  Margo L. Sm.	ith					2. Date of Do Month	Da 26	2010	3. Time o			
Medica kamine		4a. Facility Name (If not institution, gi				4b. City, Town, or	r Location of Dea			. County of Death				
.amme		1142 Rosemont	Drive			Knoxvi.	lle		F	rederic				
neral ector		218-34-2836	Sex 7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth <i>Pay, Year)</i> 11939	9. Birth	place (State intry) Y Land	or Fore		
	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside C	City Lim		
e da	ō		ale		xvill			1 ☐ Yes						
notifi	rec	MD Frederic	CK.	KIO	XVIII	10f, Zip Code			intry?					
st be	a D	1142 Rosemont D	rive			2175	8			USA				
ir mu	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Was Decedent of H		Specify Yes or N	0-	14. Race - Amer Black, White				
New 3	2	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced		lo		1 □Yes 2 <b>X</b> No	Specify:	110 1 110 111, 010.1		Specify: Whi				
dica	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	1	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of we	orking	16b. K	(ind of Business/I	ndustry			
ow a	m D	Elementary/Secondary (0-12)	College (1-4or 5-	+)		00 NOT use retired gage Brol								
a 8	ပ္ပ	17. Father's Name (First, Middle, Las	et)		PIOL	gage broi		me (First Middle	Banking me (First, Middle, Maiden Surname)					
8 0	m	Roy Benjamin Car	<i>'</i>					et Greer		Maiden Surname)				
Tagi	<u>٩</u> .	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route												
r trau		Gilmer H Smith, Husband 1142 Rosemon									,			
othe		20a. Method of Disposition				sition (Name of natory or other place		Date		ocation - City or T	own, State			
ry or		1 Burial 2 ☐ Cremation 3 C 4 ☐ Donation 5 ☐ Other (Spec		I .	Cernet			/2010	Love	ettsville,	<b>V</b> A			
any inju once,		21. Signature of Funeral Service Lice	onsee William	ma)	i	Name and Addre	ss of Facility	-						
as the burial-transit  ue ical  ue ical  ue ical	Exam	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									Approxima Interval Be Onset and	ate etween I Deat		
letached for use	/ Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	y en in Part I.	23e. Did	tobacco	23d. Date of deli Month	Day	Ye ar						
Id be	d by							1 🗆	Yes 2	2 No 3 Probably 4 Unknow				
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or, p	a l	25. Was case referred to medical					26 Place of Do	1 ☐ Yes eath (Check only		o 1 ∐Yes	2 □No			
	0	examiner? 1 ☐ Yes 2 🗹 No	Hospital: 1   Inpatie	nt 2∏EF		nt 3 DOA Oth	or.	- /		6 ☐ Other (Spec	rify)			
Jeral F		27. Manner of Death	28a. Date of Injur (Month, Day	y 28	Bb. Time of Injury		y at	28d. Describe			y)			
	atio	1 Hatural 5 Pending investigation	on	nijury		Yes 2 ☐ No								
Cortification:	Sertific	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		ry - At home :. (Specify)	e, farm, stre					(Street and Number or Rural Route Number, wn, State)				
		29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of aminer: On the basis of and manner sta	examination	edge, death n and/or in	n occurred at the tir vestigation, in my c	me, date and place opinion, death occ	ce, and due to th	e cause(s e, date an	s) and manner as id place, and due	stated. to the cause	(s)		
pletely fill	ᅙ	and manner stated.									Day Voari			
Modical		29b. Signature and title of certifier				25C. LICEIIS	14			ate signed (Month	i, Duy, rour,			
completely fill		29b. Signature and title of certifier	e	My		D 29C. Licens	0067	131	8	171/10				
completely fill	Σ	29b. Signature and title of certifier  30. Name and address of person who	o completed cause of de	eath (Item 23	3a) (Type, I	D	0867	131	8	171   10				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12408 IXIC Lou Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Jashing ton (punty TOWN Washington Hospital Hagers 9. Birthplace (State or Foreign 6. Sex If Under 24 Hrs. Social Security Numbe 7. Age (In vrs. last birthday If Under 1 Year 8. Date of Birth Funeral Days 1 🗆 M 2 🗓 F 60 Months Min 220-58-3921 Maryland Director Oct. Usual Residence of Decedent or 28a-f show 10b County filed within 72 hours after death with the Maryland Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🏋 Yes 2 🗌 No MD Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 352 Yorkshire Drive 21740 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give "natural", or þ 1 Never Married 2 😾 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. White Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Account Manager Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jack Hobert Stevens Janis Ella Ardinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Robert L. Smith, Jr./Husband 352 Yorkshire Drive, Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 9/8/2010 Hagerstown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel J. Mul 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Te to (or as a consequence of) Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death. Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No for Month Day Year rate has been signed by the spage 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform death? this certificate 2 🗌 No Yes 2 No 1 Yes neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier сопрете within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State Registrar Date filed (Month, Day, Year)

SEP 1 5 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			State of Maryland	/ Depa	artment of H	ealth and N	/lental Hyg	giene			
		1 - State Registrar		Cei	rtificate of L	Death	F	Reg. No. 2	0	28985	
Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month		rear :	3. Time of Death	
/Medic	al	<u>Michele</u> Elean					August			5:30 A <sup>M</sup>	
Examin	er	4a. Facility Name (If not institution, give s	reet and number)	•		Location of Death		4c. County of		,	
Funeral		Kline House  5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year		8. Date of Birti (Month, Day		deric  B. Birthplace	ce (State or Foreign	
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pu v		Usual Residence of Decedent  10a, State 10b. County	10c. City, To						104	leside Obelliele	
faryla sho	ō		,						100.	I. Inside City Limits 1 ☐ Yes 2 ☑ No	
the N 28a-1	Director	Maryland Frederick  10e. Street and Number		MOU	rovia 10f. Zip Code			10a Citizen of Wh	at Country		
3a or	ā	10915 Fingerboard	Road		· ·	770		10g. Citizen of What Country?  United States			
death ms 2	Funeral		2. Was Decedent Ever in U.S.	13. \	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Race	- American	Indian,	
or ite		1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		lf Yes, specify Cubar 1 □ Yes 2 🛣 No	n, mexican, Puerto Specify:	Hican, etc.)		White, etc.		
be filed within 72 hours after death with the Maryland and Hygiene.  Hygiene.  ed other than "natural", or items 23e or 28e-f show event, the Medical Examinar mint to profibe deliance.	ed by	3 Widowed 4 Divorced	Year or Dates:					Specify:	Whi		
in 72	Completed	15. Decedent's Education (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of work	ing	16b. Kind of Busi	ness/Indus	stry	
be filed within tal Hygiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		flexologis			Me	dical		
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wuld b Ment Ment arked	To 8	Milton Edwar	d Amoss			Mildr	ed Jo	sephine	Cur	ran	
2 sho		19a. Informant's Name/Relationship (Typ	·		ng Address (Street a					*	
T and Health		Elizabeth Rebecca 20a. Method of Disposition									
ages nt of nt of		1 ☐ Burial 2 🔀 Cremation 3 🗆 Re	moval from State ceme	etery, cřen	sition (Name of natory or other place	<del>)</del>	Date	20c. Location - C	•		
nit. P. artme		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenset			rney Crema			Woodbin			
permit. Pages 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any injury or other traumatic event, ins Maxis once.		Yunnita Ry	Homes M0095	7   Gō	Name and Address DING HOME Everly I	Crematic	n Servi	ce P.O. ] Clarksv	Box 7	84 MD 21029	
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Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	000	ocare	CACIOA	0		Ó	Onset and Death	
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ted	Examiner	it any tracing to immediate cause. Enter Underlying Cause (Disease or injury	sa offir								
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Attending Physician: The law requires that the death certificate in death.  ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	230. Was decedent pregnant	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		Ectopic pregnancy			23d. Date			
the at	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of death		Other (specify)			Mont	h Da	ay Year	
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or Al after d Direc in by	ertification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Number n, State)	or Rural R	loute Number,	
spital lours neral / filled	O	29a. Certifier Certifying Physi	cian: To the best of my knowled	dge, death	occurred at the tim	ne, date and place.	and due to the	cause(s) and man	ner as stat	red.	
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only /2   Medical Examine one)	er: On the basis of examination and manner stated.	and/or inv	vestigation, in my op	pinion, death occur	red at the time, o	date and place, an	d due to th	ne cause(s)	
Vithi Vomp	Ž	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed (	Month, Da	y, Year)	
		6,600	MD		D68	401		8/23	110		
		30. Name and address of person who com	pleted cause of death (Item 23	a) (Type, I	Print)	7 1	Cala	1	, ~ ,		
Stat	0	31. Date filed (Month Date Year)	32 Jegistrar's Signature	acl	HUR, T	reder	ICK	MDO	21 /1	01	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 9:15 A Marcus N. Scott August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 1309 Winding Waye Lane Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, ept 24 1**X** M 2 □ F Hours Year 579-14-3744 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? 1309 Winding Waye Lane 20902 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2X No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Mail Room 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcus Scott Annie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 Peggy F. Scott/wife 1309 Winding Waye Lane Silver Spring, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 8/28/2010 Woodbine, Maryland 21. Sign ture of Funeral Service Licer Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Hostate** Carcer metastases disease or condition resulting in death) months Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

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To the Funeral Director; Aft completed filled in by the fur

funeral director,

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Completed

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Certificate:

Medical

29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

**Examiner** 

**Funeral** 

Director

or 28a-f show notified at

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death

Maryland 21215-0036

Baltimore,

er than "natural", or items 23a on the Medical Examiner must be

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should be filed with and Mental Hygien is marked other ti

permit. Page 1 and 2 sh Department of Health an Important: If item 27 is 1 any injury or and

other traumatic

Director

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Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown

25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Death

26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at

24b. Were autopsy findings available prior to completion of cause of death? performed' 2 🗌 No Yes 2 No 1 Yes

1 Natural 5 Pending Investigation ☐ Accident Suicide 6 Could not be 4 Homicide determined

1 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

28d. Describe how injury occurred

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier

29c. License number D37142

2 🗌 No

8-24-2010

ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr 1355

Paccard

Rockville

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ tugust Richard Lee Taylor 7870 720 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George 8. Date of Birth (Month, Day, Year) Mar 18, 1947 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Days Min. Hours Months 1 🔽 M 2 🗆 217-42-5203 Director 63 ME Usual Residence of Decedent show "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Prince George Upper Marlboro 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10110 Campus Way South 20774 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Africanδ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify Completed 3 X Widowed 4 Divorced American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10 College (1-4 or 5+) it. Page 1 and 2 should be filed within artment of Health and Mental Hygiene ortant: If item 27 is marked other thi injury or other traumatic event, the truck driver Coca Cola Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Taylor Novella Mae Dix 19a. Informant's Name/Relationship (Type, Printdaughters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tori Taylor & Palmea Love 10110 Campus Way South, Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page
Department c
Important: If
any injury or
once. 4 ☐ Donation 5 ☐ Other (Specify) St.James AME Cemetery 9/4/2010 Snow Hill, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 21. Signature Ineral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on which line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last signed by the attending physician and be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2X No Other: မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined To the Hospital o within 24 hours aff To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUCK ROOM FOZIA u wahabe 1000 Registrar's Signat State Registrar

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

To the Hospital or Attending

4 | Homicide

(Check only one)

29b. Signature and title of certifier

womach

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925

29a. Certifier

Medical

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Walsh

29c. License number

00055325

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d, Date signed (Month, Dav. Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Bishop

amend 23a pt. I.B. 25.27.28a F. per me 9925 3-8-12 sm. 1 - For State Registrar 28989 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 28 Month 8 6:50PM Karen Walker Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Meryland Med Center Social Security Number 6. Sex 17 A - 17 8. Date of Birth (Month, Day, Year) Hmore If Under 24 Hrs. Hours Min. **Funeral** If Under 1 Year 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Days 217-72-6037 Washington. Director 53 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Cecil Rising Sun 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be Funeral ms 23a 1724 Theodore Road 21911 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2X☐ No Specify: Completed "natural" 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Two Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic even ൧ Albert Schlueter Darlene Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Thomas Walker 1724 Theodore Road, Rising Sun, Maryland (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
R.A. Ferris & Co. Inc. 20a. Method of Disposition West Chester Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/01/10 Pennsylvania 21. Signature of Funeral Service License Lee And Address (Facility & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Y 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Hypotac Due to ( f as a consequence of): disease or condition resulting in death) Medical Examiner Neck Injury(Cervical Fracture C2) Secure dially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): use as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiac 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy perform Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer Hospital or Attending 1 Natural 2 X Accident 5 Pending 1 Tes 2 **K** No subject fell down stairs fd 8-24-10 Investigation unknown M 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nymber or Bural Route Number, City or Town, State) 1724 Theodore Rd. determined Home Rising Sun, MD Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Klizabeth ser0 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

CED

3altimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

arka

State of Maryland / Department of Health and Mental Hygiene 28990 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 8:35 Charles Edward Wagner August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death <u> Hospice House</u> Callaway Mary's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F Director 214-20-9640 84 ugust 2 1926 Maryland Usual Residence of Decedent 28a-f show 10b. County ir than "natural", or items 23a or 28a-f shother the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 27121 Cape St. Mary's Drive 20659 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: 3 Divorced White Year or Dates. 1944-1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Refinery Supervisor 0il Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ္ Edward Ambrose Wagner Ethe1 Ε. Pocklington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 st tment of Health a tant: If item 27 is Edna Mildred Wagner / Wife 27121 Cape St. Mary's Drive, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of Hall Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State September 4, 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Kenneth 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Completed by Physician/Medical Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown s been signed by the should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? has xolenia performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes Division of Vital the funeral director, 25. Was cas 26. Place of Death (Check only one) Be 1 Yes Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \( \sum \) Yes 2 \( \sum \) No 1 Natural injury 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by Homicide determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 31-10 a breng Boulevard 22576 MacArthur ath (Item 23a) (Type, Print) California, MD 20619 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	·	-	tificate of L		-	Reg. N	2010	28991			
F	hysicia	n/	1. Decedent's Name (First, Middle, Last Emmett Clayto					2. Date of De	eath	ay Year	3. Time of Death			
	Medic Examin	al	Emmett Clayto  4a. Facility Name (if not institution, give s			4h City Town o	Location of Death	August	_30		6:00 A M			
	<b>L</b> Xaiiiii	CI	4275 Marion Lane			Waldo		,	1	Charles				
	uneral irector		5. Social Security Number 6. Se. 407–05–3317	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 02/04/		g. Birthp Coun Kenti	place (State or Foreign try) ucky			
p	at at	ī	Usual Residence of Decedent  10a. State 10b. County	140c C	ity, Town or Lo	ration		1,,			0d. Inside City Limits			
larylar	3a-f st iffied a	Director	Maryland Charle		aldorf	cation					1 Yes 2XXNo			
the M	a or 28 be not	I Dir	10e. Street and Number			10f. Zip Code			10g. C	Citizen of What Coun	ntry?			
th with	ns 23; must I	Funeral	4275 Marion Lane			2060				USA				
1 <b>3-UU36</b> 2 hours after deal	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates.		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2X No		pecify Yes or No- p Rican, etc.)		14. Race - Americ Black, White, e Specify: Whi	etc.			
13-C	"natu edical	plet	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working				Kind of Business Inc	dustry			
naryland 21215-UU30 should be filed within 72 hours after and Mental Hyciene	r than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		life. DO NOT use retired) Policeman				t. of Def	ense			
filed w	d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	<del></del>					
Yland Jid be filed	arkec atic e	욘	Gazetyn Beamen											
Mar 2 shou th and	7 is n traum	19a. Informant's Name/Relationship (Type, Print)  Susan J. Walker/Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 4275 Marion Lane, Waldorf, Maryland 20									*			
and Heal	item other		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of	1	Date						
Page	ant: If	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City												
bantimore, permit. Page 1 and Department of Hea	Imports any inju		4 Donation 5 Other (Specify)  Maryland Veterans  109/07/2010   Cheltenham, MD  21. Signature of Funeral Service Licenses  MO0817  22. Name and Address of Facilit Brinsfield-Echols Funeral Home 30195 Three Notch Rd., Charlotte Hall, MD 20622											
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	ications that caused the dea e cause on each line.	th. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between			
	si <del>cia</del> n, edical		mmediate Cause (Final disease or condition and death)  Onset and Death  Onset and Death											
	miner			Due to (or as a conseq		nitim					2 weeks			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events  Due to (or as a consequence of):  ymmuetic ancer											
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ecuted	and -transi	xam	Cause (Disease or iinjury that initiated events	Due to (or as a conseq		muedic	ancer				7 weeks			
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th certificate be executed	ttending physician and or use as the burial-transi	_	Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d	ancy	Ectopic pregnanc				23d. Date of delive	ery			
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	~y	Decedent's Name (First, Midd	le, Last)								2. Date of De	eath			3. Time o	
sicia edic		MAXIN	E	WA	RD						Month August	25 Day		Year 010	2245	P M
min		4a. Facility Name (If not institution	_				4b. City,	Town, or	Location	of Death		4c.	County o	of Death		
		Alice Byrd Tawes Nursing Home					Crisfield Somerset    Crisfield   Somerset   Gunder 1 Year   If Under 24 Hrs.   B. Date of Birth   9. Birthplace (State									
ral or		5. Social Security Number $\begin{bmatrix} 6. \text{ Sex} \\ 1 \square \text{ M} & 2 \cancel{\text{M}} \text{ F} \end{bmatrix}$ 7. Age (In yrs. last birthday) $\begin{bmatrix} \text{If U} \\ \text{Mor} \end{bmatrix}$ Yrs.						Days	Hours	Min.						or Foreign
	ŀ	Usual Residence of Decedent	l										1	Mary.	Tand	
<u>o</u> nce.		10a. State 10b. County	/		10c. Cit	y, Town or L	ocation							1	0d. Inside C	
	Director	Maryland	Some	cset					isfi	eld						s 2X No
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	Funeral	11. Marital Status			dent Ever in U	.S. 13.	Was Dece	dent of Hi			ecify Yes or No	o- T	14. Race		an Indian,	
		1 Never Married 2 Ma					ecify Yes or No Rican, etc.)		Black	, White, ໄດ້	<sub>etc.</sub> Nhite					
	by	If Yes, Give 1 □ Yes 2 No Specify:										Specify:				
ŀ	Completed	15. Decede (Specify only high	al Occupa ork done d	lurina mos	st of work	ing	16b. K	ind of Bus	siness/Ind	dustry						
	Idm	Elementary/Secondary (0-12)		College (1	-4or 5+)	life.	DO NOT U	ise retired; MStre				Clo	athin	thing Manufacture		
	ပ္	17. Father's Name (First, Middle	, Last)			]	Dea	IIID CE C		er's Name	e (First, Middle	<u> </u>				
1	To Be	Edgar McCre	Edgar McCready									son				
		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 4383 Beechwood Place - Crisfield, Marvl													7	
Į		Earl R. Ward, Jr. (Son) 4383 Beechwood Place - Crisfield, Maryland 21817														
		20a. Method of Disposition  1 National 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Asbury Cemetery  August 28, 2010 Crisfield, Maryland														
		4 □Donation 5 □ Other (			ASI				<u>i</u> _							
		21. Signature of Europe Legrido V Consee 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, Maryland 21817														
ĺ		23a. Part1. Enter the disease, of	r complica	tions that ca	aused the deal								27 130	IL y I C	Approxima	ate
ŀ	8 9	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Dea										etween I Death				
		disease or condition resulting in death)  a.   SEPSIS  Due to (or as a consequence of):														
ı		Sequentially list conditions.  b. CHOLANGIT (S														
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):														
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):														
	edic	o.														
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c		come pf pregnirth 2 Peta		□Ectopic p	regnancy	onancy 23d.					d. Date of delivery		
	sicis	in the past 12 months? 1 ☐ Yes 2 No			ant at time of		Other (s						Mon	ith	Day	Year
	Phy	9 ☐ Unknown  Part II. Other significant condit	lone contri	buting to de	ath but not res	ulting in the	ındorlying /	cause dive	n in Part	1	23e Did	tobaccou	ica contri	bute to t	he cause of	death?
	by	Fait II. Other Significant condi-		C V_D		aiding in the	andenying (	Jause give	ni jii rait	1,					oably 4	
	etec		/1-								24a. Was	(				
	Completed										auto		p	rior to co eath?	ppsy findings mpletion of	
		25. Was case referred to medic	al						26 Plac	e of Deat	1 Yes		1	□Yes	2□ No	
	To Be	examiner? 1 ☐ Yes 2 No		pital:	npatient 2	ER/Outpatie	nt 3 D	OA Othe	APT - A		ome 5□Res		6 □Othe	er (Specif	fy)	
		27. Manner of Death Natural 5 ☐ Pendi	na	28a. Date o	of Injury h, Day Year)	28b. Time Injury	of	28c. Injury Work			28d. Describe					
	catic	2 Accident invest	igation				М		Yes 2□	No						
	Certification:		mined	28e. Place buildir	of injury - At h ng, etc. <i>(Sp</i> eci	ome, farm, s	treet, factor	y, office			28f. Location (			er or Rura	al Route Nu	mber,
		29a. Certifier Certify	na Physic	lan: To the	best of my kno	owledge, dea	th occurred	at the tin	ne, date a	nd place.	, and due to the	e cause(s	) and mar	nner as s	stated.	
	Medical	(Check only 2 1 Medica	I Examine	r: On the ba	asis of examina	ation and/or i	nvestigatio	n, in my o	pinion, de	ath occur	rred at the time	, date an	d place, a	and due t	o the cause	
	Me	29b. Signature and title of certifi	er		,	_	29	c. License	number	_ ===		29d. Da	te signed	(Month,	Day, Year)	
		D 48098									08	3/26	120	10		
- 1	ı	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A Vyay Kaum banatian 201 Hall Highway, Crifield MD 2 18 17  31. Date filed (Month, Day, Year)  AUG 3 0 2010  August 12 18 17												· · · Com	/ mp	21817
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** Ola Washington 2010 8 29 0925 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury
If Under 24 Hrs. Anchorage Nursing & Rehab Wicomico Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 27 F Months Days Hours Min. Director 230-52-5680 8-20-1929 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

The than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Weddall Examinar is ust be notified at Director Wicomico 1XYes 2 □ No Salisbury MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Times Square 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: 2 SpecB:lack 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Domestic Worker h and Mental Hygie Farming permit. Pages 1 and 2 should be file Department of Health and Mental HImportant: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ukn Ukn ပ 19a. Informant's Name/Relationship (Type. Prip aughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7210 Shockley Rd, Snow Hill, MD 21863 Willie Mae Washington 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Hope Baptist 9-4-2010 Stockton, MD 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, MD 21801 Funeral Home Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) **Physician** AD /Medical Due to (or as a consequence of): Examiner ASCVI Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∭ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 0 1 2010

. M.D

29b. Signature and title of certifier

Babulal Das. 106 Milford ST # 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

504 B. Salisbury, MD21804

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lloyd Wm. Wood August 2010 3:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5623 Well Spring Court New Market Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours 1273171927 333-22-5999 Director 82 Yrs IL Usual Residence of Decedent show 10a. State 10b. County with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🔀 No MD Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5623 Well Spring Court 21774 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates. 1946-47 White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) h and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Naval Architect Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Wood permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. traumatic Martha Duerr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6831 Whooping Crane Way New Market, MD 21774 Paul Wood/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Ardent Cremation Svc. 8-27-2010 Hanover, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus interval Between Immediate Cause (Final Onset and Death METSATIC ABENOCALUMONA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner DAYS. PLEURAL EFFUSION Secuentially By conditions Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed and-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the a d be detached f g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes ၉ 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directions. 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical King Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signa 29d. Date signed (Month, Day, Year) D0062223 Aug 26, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1967JUNG, REDELICE, MD 21702. BOCALUM, MD AVEEN

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene							
			1 - State Registrar Certificate of Death Reg. N2 0   0 28995	)						
	Physicia Medi		1. Decedent's Name (First, Middle, Last)  ELIZABETH  B. WHITLOCK  2. Date of Death  Month  Aug 12 2010 6:50A M  Company Sear Aug 12 2010 6:50A M  Aug 12 2010 6:50A M	l						
	Examir	er	4a. Facility Name (if not institution, give street and number)  14005 COVE LANE APT 101  4b. City, Town, or Location of Death  ROCKVILLE  MONTGOMERY							
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 H F 60 Yrs.   10 M 1 M 2 H F 60   10 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1	7						
	yland f show ed at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
	the Mar or 28a- se notifi	I Director	MD MONTGOMERY ROCKVILLE  10e. Street and Number  10g. Citizen of What Country?	)						
	ems 23s	Funeral	14005 COVE LANE APT 101 Z0851 USA  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-							
9000	urs after de tural", or ite al Examine	þ	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Specify:  3 Widowed 4 Divorced Specify:  Armed Forces?  1 Yes 2 No Specify:  Specify: SLACK							
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  12 TH  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  CERT, NURSING ASSTIANT  16b. Kind of Business Industry  NURSING FACILITY							
land	d be filed Aental Hy irked oth tic event	To Be	17. Father's Name (First, Middle, Last) PAUL BRAXTON  18. Mother's Name (First, Middle, Maiden Surname) JULIA BRAXTON							
Mary	d 2 should be file alth and Mental I 127 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  12534 GRANITE RIDGE DY. GAINHUSBURG MD 20878							
imore,	permit. Page 1 and 3 Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  5 MINTSBURG CREM.  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. MINTSBURG CREM.							
Balti	permit. Page Department o Important: If any injury or once.	- 85	21. Signature of Funeral Service Licensee  22. Name and Address of Facility GARY L. ROLLINS FUN HUME  10 WEST SOUTH ST FREDERICK, MD 21701							
	-nysician/	0.00	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between	1						
	Medical Examiner	resulting in death)  Due to (or a. a consequence of):								
	uted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.							
09	icate be executed physician and s the burial-transit	edical E	resulting in death) Last  Due to (or as a consequence of):  d							
876	rtificat ing ph e as th	Mec	IF FEMALE:							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  Within 24 hours after death.  Completed Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1							
Division of Vital Records, P.O.	quires that t en signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown	J						
Recor	The law rec cate has bee page 2 sho	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1							
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?  26. Place of Death (Check only one)							
<u>_</u>	Physi this o	2	1 Inpatient 2 ER/Outpatient 3 DOA Wissing Home 5 Residence 6 Other (Specify)	_						
o uoi	tending I death. tor: After the funer	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M 1 Yes 2 No							
Divis	ital or At urs after or ral Direct lled in by		4 Homicide determined determined determined determined 286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	100						
	the Hosp hin 24 ho the Fune npleted fi	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	d.						
D	vitl D COU		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  D66689  29d. Date signed (Month, Day, Year)							
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MUHAMMAD AMBR. MD. JOHN HOPKINS HOSP. PAYWOKE IND.							
ı	Stat Registra	<b>-</b>	31. Date filed (Month, Day, Year)  32. Repsec's Signature  SEP 15 2010  Repsec's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ August 28, 2010 Year 12:30 p.Mm Virginia Mary Yeatman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months Days Hours Min Director Mary Land 220-62-6444 58 Usual Residence of Decedent show 10a. State 10b. County 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f s idical Examiner must be notified 1 ☐ Yes 2 X No Maryland St. Mary's St. Inigoes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17680 St. Inigoes Road 20684 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? þ Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John M. Cooper Margaret A. Bayne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19130 Tidewater Court, Lexington Park, MD Cynthia A. Morgan/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Michael's Cem 09/01/2010 Ridge, Maryland Signature of Officeral Service Edward N. Bri 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield 22955 Hollywood Road, Leonardtown, MD M00052 Part 1. Enter the disease, or complications that caused the death. Do not unter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 8 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). cate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐
4 ☐ Pregnant at time of death 5 ☐ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Year Dav g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed?

Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **P** No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

James P. Jarboe,

D 06419

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4035 Three Notch Road, Hollywood, MD

The definition is the least of the past of

29b. Signature and title of q

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** АМ Betty Louise Arteaga 09-11-2010 7:30 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 2803 Bluebell Ct Abingdon If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 06-18-1955 Birthplace (State or Foreign Country) Texas 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛛 F 449-11-5799 55 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2/17No MD Harford Abingdon Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2803 Bluebell Court 21009 US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Deceded of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes Z☐ No White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Director Muni 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther Parrish Edamae Mullen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Weil (spouse) 2803 Bluebell Court, Abingdon, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Marmation 3 ☐ Removal from State 09/16/2010 Bayview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and -trai Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-i Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year 4☐ Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month eptembe 2108PM Janet Jean Betters Medical 4a. Facility Name (if not institution, give street and nur Examiner 4b. City, Town, or Location of Death County of Death Anne 6 le Funeral Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 K F Months Days Hours Min 9-28-1 935 509-42-1674 Director 74 Usual Residence of Decedent oortant. If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2X No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7805 Elberta Drive 21144 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Yes 2X If Yes, Give Year or Dates. 1 Never Married 2X Married 1 Yes 2 X No Specify: 3 Nidowed 4 Divorced Specify: White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Intelligence Department US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Greiner Ada Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard B. Betters Husband 7805 Elberta Drive Severn Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 10-7-2010 Arlington, Virginia 21. Signature of Funeral Service Lice 22. NaDona Idson Fartuneral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 M01176 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whick, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and if for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate funeral director, pag 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Physician/ Day Year Larry W. Bowman 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE WASHINGTON MEDICAL ( 6LEN DURNIE AUNE HRUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-11-1952 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F North Carolina **Director** 241-88-2820 58 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.4 ehrm any injury or other traumatic account. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗆 Yes 2 🔀 No Anne Arundel MD Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20794 2078 Montevideo Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 
Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Paralegal United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charlie W. Bowman Emma J. Fern Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **SEMMAN** Gayle B. Bowman / Wife 2078 Montevideo Road Jessup, Maryland 20794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 109-17-2010 Signature of Funeral Service 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ (-WCCPUD CONTA HEPANG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, CO+ Gues Examiner cause. Enter Underlying Cause (Disease or linjury Due to for es e nonsequença ofisigned by the attending physician and deed be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year Day page 2 should be detached 1 ☐ Yes ∠ ☐ g ☐ Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 Yes 2 No 3 Probably 4 Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' after death.

Director: After this certificate Yes & No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other 2 HO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 16 2010

Tsion Berhane, MD 301 Hospital Drive Glen Burnie, Maryland 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May E. Belcher September 14, 2010 Year **Physician** 9:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 5411 Walther Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 218-03-67**39** 101 Dec 21, 1908 MD Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 XX es 2 □ No MD N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5411 Walther Avenue 21214 U.S.A Funeral 14, Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify Specify: <u>۾</u> White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within Elementary/Secondary (0-12) 12 College (1-4or 5+) Telephone Operator C&P Telephone permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other trailment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl William Taylor Grace Mable Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis G. Silverman (Attorney) <u>3600 Roland Avenue</u> SIE. 6 Balto. MD21211 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 9/17/2010 Baltimore, MD 21. Signature of Funeral Service Liberal ee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Balto, MD 21211 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 1☐ Yes 2 No I or Attending Physician: after death. Director: After this certifice funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00060489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Suite K Baltimore, MD 31236 Daven mo KAREN 31. Date filed (Month, Day, Year) SEP 16 2010 State Registrar